Monitor
Making the health sector work for patients

NHS England

2015/16 National Tariff Payment System: A consultation notice

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Annexes

Please note: The annexes to Part II are presented as **separate files** (in PDF and Excel), available here.[1]

Annex 1a: Glossary (PDF)

Annex 4a: Additional information on currencies with national prices (PDF)

Annex 4b: Maternity data requirements and definitions (Excel file)

Annex 5a: National prices (Excel file)

Annex 5b: Data cleansing method (PDF)

Annex 5c: Admitted patient care (APC) structured query language (SQL) tariff model handbook (PDF)

Annex 5d: APC tariff model (Excel file)

Annex 5e: Outpatient procedures (OPROC) model (Excel file)

Annex 5f: Outpatient attendances (OPATT) model (Excel file)

Annex 5g: Accident and emergency (A&E) model (Excel file)

Annex 5h: Unbundled services model (Excel file)

Annex 5i: Maternity pathway model (Excel file)

Annex 5j: Other national prices model (Excel file)

Annex 5k: Best practice tariff (BPT) model (Excel file)

Annex 6a: Market Forces Factor payment values (Excel file)

Annex 6b: Specialised services and eligible providers (Excel file)

Annex 7a: Specified acute services for local pricing (PDF)

Annex 7b: High cost drugs, devices and listed procedures (Excel file)

Annex 7c: Mental health clustering tool booklet (PDF)

Annex 7d: Ambulance and patient transport services (PDF)

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

A number of supporting documents (available here[1]) will help your reading of the '2015/16 National Tariff Payment System':

- 'A user guide to '2015/16 National Tariff Payment System' (PDF)
- 'Enforcement of the national tariff for 2015/16' (PDF)
- 'Guidance on locally determined prices for 2015/16' (PDF)
- 'Local variations template' (Excel)
- 'Local variations worked example' (Excel)
- 'Local modifications template' (Word)
- 'Local prices template' (Excel)
- 'Guidance on mental health currencies and payment' (plus four Excel annexes)
- 'Impact assessment for the proposals set out in '2015/16 National Tariff Payment System: A consultation notice'' (PDF)
- 'The maternity pathway payment system: supplementary guidance' (PDF)
- 'A guide to the Market Forces Factor' (PDF)
- 'National tariff information workbook' (Excel)
- 'Supporting innovation in the NHS with local payment arrangements' (web page), hosting:
    - 'Improving Access to Psychological Therapies: a local payment case study' (PDF)
    - 'Capitation: a potential new payment model to enable integrated care' (PDF)
- 'Worked example to Default 50:50 gain and loss sharing rule' (Excel)
- 'A model for non-mandatory prices' (Excel)
- 'Towards an NHS payment system that does more for patients' (PDF)

Cover note to the '2015/16 National Tariff Payment System: A consultation notice'

This document – the '2015/16 National Tariff Payment System: A Consultation Notice'[2] – sets out the proposed national tariff for 2015/16. It is subject to a statutory consultation process,[3] in which your views and responses are sought to the proposals agreed by Monitor and NHS England.[4] **The consultation period ends on 24 December 2014 – this is last day for submitting a response.**

The document is in two sections:

- Part I explains the notice and the consultation process. It is supported by Annex A and Annex B.
- Part II contains our **proposals** for the 2015/16 national tariff. It is important to note that we have set this proposal out as a version of the proposed national tariff – ie it is written as we propose the 2015/16 national tariff to appear in terms of final format, structure and content, including the relevant annexes. This is why it may refer to items in the past tense that have yet to occur, for example the consultation period. It is supported by Annexes 1a to 7d.

In addition to the notice itself, Monitor is publishing an impact assessment of the proposals. There are also various other supporting documents, in their proposed final format. We are in particular interested in feedback on the documents covering:

- local payment examples
- mental health guidance.

The reader may note that the format of this consultation notice has changed from that used last year. We hope that these changes will help in understanding and responding to this consultation notice.[5]

[2] For the complete document set see https://www.gov.uk/government/consultations/national-tariff-payment-system-201516-a-consultation-notice
[3] See section118 of the Health and Social Care Act 2012 ('the 2012 Act'). The proposals are also subject to consultation by virtue of section 69(7) of the 2012 Act, which requires consultation on proposals that are the subject of an impact assessment.
[4] Throughout the document the terms 'we' and 'our' are used to refer to both NHS England and Monitor. It is clearly stated when a specific role or responsibility falls to either NHS England or Monitor. This applies mostly to enforcement, applications and disclosure requirements, where Monitor is the responsible body.
[5] We have used as our template for Part II last year's national tariff document, the '2014/15 National Tariff Payment System' to ensure consistency and cohesion in presenting our proposals for the 2015/16 national tariff.

The pricing framework established by the Health and Social Care Act 2012 and our proposals

The Health and Social Care Act 2012 (‘the 2012 Act’) provides for NHS England and Monitor to agree proposals for each national tariff and sets out the respective roles and responsibilities of the two bodies. It sets out what **must** be included in the national tariff and what additionally **may** be included, and provides for a consultation process. As required by the 2012 Act, this document is published by Monitor, but the content has been agreed jointly between NHS England and Monitor.

The pricing provisions of the 2012 Act provide for a comprehensive payment system, including not only a set of specific currencies and associated prices, but also a set of principles, rules and methods. For this reason, and similar to the approach undertaken for last year’s tariff, we will give the national tariff for 2015/16 the title: the ‘2015/16 National Tariff Payment System’.

Consistent with the 2012 Act, we propose that the ‘2015/16 National Tariff Payment System’:

- specifies a set of **healthcare services** provided for the purposes of the NHS which are to have **national prices** (referred to as ‘currencies’)[6]
- specifies the **method** used for determining the **national prices** of those specified services[7]
- specifies the **national price** of each of those specified services (whether as an individual service, or as a bundle of services, or as part of a group of services)[8]
- specifies the **methods** used for approving an agreement between a provider and a commissioner to modify a nationally determined price and for determining a provider’s application to Monitor to modify a nationally determined price[9] (we refer to these modifications as **local modifications**)
- provides for **rules** under which providers and commissioners may agree to vary the **currency** or the **national price** of services[10] (we refer to these variations as **local variations**)

[6] 2012 Act, section 116(1)(a)
[7] 2012 Act, section 116(1)(b)
[8] 2012 Act, section 116(1)(c)
[9] 2012 Act, section 116(1)(d)
[10] 2012 Act, section 116(2)

- specifies variations to the national price for a service by reference to the circumstances in which the services are provided or other factors relevant to the provision of that service (we refer to these as **national variations**)[11]
- provides for **rules** for determining the price payable for services that do not have a specified national price[12]
- provides for **rules** for determining which currency applies in cases where a service is specified in more than one way (this is, with more than one currency)[13]
- provides for **rules** relating to the **making of payments** for the provision of healthcare services.[14]

The national tariff may also include **guidance** as to the application of the rules, local modification methods and national variations referred to above, and commissioners must **have regard** to such guidance.[15]

This statutory consultation notice sets out the currencies, prices, variations, rules and methods that Monitor proposes to include in the 2015/16 national tariff. Monitor aims to publish the '2015/16 National Tariff Payment System' in early 2015. As we note later, this date is provisional and will only be confirmed after the consultation period.

The '2015/16 National Tariff Payment System' and associated supporting documentation would have effect for the financial year 2015/16. The existing '2014/15 National Tariff Payment System' and associated supporting documentation would have effect only in relation to the previous year (2014/15).

Engagement for developing our '2015/16 National Tariff Payment System' proposals

NHS England and Monitor conducted an engagement exercise to explain our developing proposals and invite views on those proposals. This provided an opportunity for stakeholders to contribute ahead of the publication of this statutory consultation notice.

In July 2014, NHS England and Monitor published the 'National Tariff Payment System 2015/16: engagement documents' (otherwise referred to as the 'Tariff Engagement Document' or the 'TED'), which explained our proposed approach and emerging policies. Readers were invited to respond via an online submission form or by email: we received approximately 500 responses.

[11] 2012 Act, section 116(4)(a)
[12] 2012 Act, section 116(4)(b)
[13] 2012 Act, section 116(6)
[14] 2012 Act, section 116(4)(c)
[15] 2012 Act, section 116(7)

Following publication of the Tariff Engagement Document, we held four workshops, primarily aimed at providers and commissioners but which attracted participants from a range of backgrounds. Staff from both NHS England and Monitor facilitated discussions, attended by a total of 245 delegates.

Details of the engagement process, along with our responses to the key themes raised, are provided in Annex A.

Further to engagement on the Tariff Engagement Document, NHS England and Monitor have engaged with stakeholders on the national tariff in a number of other ways throughout the year. These include, but are not limited to, workshops with commissioners and providers and other stakeholders, crowdsourcing surveys, bi-lateral meetings, and seeking expert clinical opinion. Feedback on the Tariff Engagement Document and from other engagement activities has directly supported the development of pricing policy for the 2015/16 national tariff, as well as informing policy development for future national tariffs. NHS England and Monitor will continue to engage with the sector on our longer term payment system redesign.

In addition to broad engagement, NHS England and Monitor have established four pricing system advisory groups to support policy development. The four groups advise on payment strategy, the national tariff, costing policy, and quality and cost benchmarking. Their advice informs the decisions made by NHS England and Monitor via our joint governance arrangements. As the advisory groups review and provide advice on issues of policy, this feedback will be taken forward as part of the cycle of payment system development.

We will also engage with the sector on any service development costs associated with new requirements in the NHS Mandate, as necessary.

Statutory consultation on the national tariff and the objection process

In this subsection, we set out the process for consultation and the statutory process for objections to the method for determining national prices, including what can be objected to, by whom, and the consequences of objections.

Unlike our earlier engagement, this document is subject to a statutory consultation process as required by the 2012 Act. This provides an opportunity for all stakeholders and others to make representations to Monitor about the proposals. In addition, it also provides an opportunity for clinical commissioning groups (CCGs) and ‘relevant providers’ (as discussed below) to object formally to the method we have proposed for determining the national prices of specified healthcare services. **The consultation period ends on 24 December 2014.**

Further detail of the statutory consultation and objection process and relevant legislative references are provided in Annex B.

What can be objected to?

The 2012 Act makes clear that not all of the proposals for the '2015/16 National Tariff Payment System' can be formally objected to under the statutory process. Specifically, only the "method or methods Monitor proposes to use for determining the national prices" of healthcare services can be formally objected to.[16]

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

In addition, the proposed method does **not** include:

- the proposed national currencies
- the proposed national variations, such as the Market Forces Factor, specialist top-ups and the marginal rate for emergency admissions
- the rules, principles and methods that we propose to govern local variations, modifications and prices.

Who can object?

The 2012 Act specifies that only objections from CCGs and 'relevant providers' count under the statutory objection process.

There are two categories of relevant provider:

- licence holders – ie those holding a Monitor provider licence, including NHS foundation trusts and independent providers
- other relevant providers as defined in the 'National Health Service (Licensing and Pricing) Regulations 2013'. Under those regulations 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.[17] This refers to current providers of the service.

For avoidance of doubt:

- the definition of 'relevant provider' includes NHS trusts that provide nationally priced services
- the NHS England teams responsible for commissioning specialised services may not formally object (the only commissioners who may do so are CCGs).

[16] 2012 Act, sections 118(3)(b) and 120(1)

A CCG or relevant provider wishing to object to the method for determining national prices proposed for the '2015/16 National Tariff Payment System' are asked to register the organisation's objection in a web-based response form.

Responses (whether using the form or submitted by email or in hard copy) should be submitted by the end of the consultation period (24 December 2014).

Consequences of objections

If 51% or more of relevant providers (measured by number, or weighted by share of supply of nationally priced NHS healthcare services) **or** 51% or more of CCGs object to the method for determining the national prices of healthcare services (as set out in Section 5 of Part II of this document), Monitor must either amend the proposals and re-consult, or refer the method to the Competition and Markets Authority (CMA) for its determination.

- Should Monitor re-consult, we will publish another consultation notice and begin the consultation process again.
- Should Monitor refer the method to CMA, objectors will have an opportunity to make representations to that body, and in doing so would have to identify the reasons for their objection and supply any relevant supporting documents.

In either case, publication of the '2015/16 National Tariff Payment System' would be likely to be delayed until spring 2015 or later. If the 2015/16 national tariff is delayed beyond 1 April 2015, the 2014/15 national tariff would continue in effect until the new tariff is published.

Other responses to the consultation

In addition to the statutory objection process for the method for national prices, we are consulting on the entire package of proposals as set out in this notice. Commissioners, providers and others can make representations to Monitor on any of those proposals. Monitor and NHS England will consider those responses before a final decision is made on publication of the 2015/16 National Tariff.

If you wish to make comments on this document, these can be emailed to paymentsystem@monitor.gov.uk

Responses must be submitted by the end of the consultation period (the last day being 24 December 2014).

1 Annex A: How the sector helped us shape the '2015/16 National Tariff Payment System'

Our stakeholder engagement process aimed to use the expert knowledge of the sector to support the development of our proposals for the '2015/16 National Tariff Payment System'. Engagement was in two distinct phases: first, to engage on the methodology that supports the setting of national prices; second, to engage on the developed prices and policies that we proposed to include in the national tariff. This allowed stakeholders to have a central role in developing robust prices and policies suitable for inclusion in the '2015/16 National Tariff Payment System'.

In this section we set out:

- the engagement process for the '2015/16 National Tariff Payment System'
- the summary of responses
- the main themes that have emerged from our engagement
- the main stakeholder groups targeted for engagement.

1.1 Activities undertaken to hear the views and comments of key stakeholder groups

NHS England and Monitor jointly undertook a range of activities to involve and engage with key stakeholders affected by the proposals:

- publication of the '2015/16 National Tariff Payment System: national prices methodology discussion paper'
- publication of the 'NHS National Tariff Payment System 2015/16: engagement documents'
- regional workshops to engage on key proposed policies
- webinars explaining the details in the published documents
- one-to-one stakeholder meetings

- informing key stakeholders using a range of traditional and social media including the trade press, Twitter and newsletters
- direct emails to stakeholder groups including NHS providers and commissioners, the third sector, license holders and patient groups.

These activities, and a range of supporting activities, are described in more detail below.

1.1.1 Publications

'2015/16 National Tariff Payment System: national prices methodology discussion paper'

In April 2014 we published a methodology discussion paper setting out our approach to the development, design and possible options for some of the proposals for the 2015/16 National Tariff Payment System. The paper had two objectives:

- To engage early on the main decisions – we sought the views of the key stakeholders about the draft proposals for the main decisions for 2015/16 national prices; these decisions were currency design, the approach to modelling prices and the framework for setting the efficiency factor.
- To collect evidence – this was the first opportunity for key stakeholders to provide views and supporting material on matters relating to the main decisions and other proposals.

Key stakeholder comments and our responses are in Appendix A to this document.

‘2015/16 National Tariff Payment System: engagement documents’

In July 2014 we published a set of national tariff engagement documents (TED) to involve the sector in our decision making. The paper highlighted the proposed changes from the ‘2014/15 National Tariff Payment System’, and summarised responses from key stakeholders relating to the ‘2015/16 National Tariff Payment System: national prices methodology discussion paper’. At this time we also published draft national prices for stakeholders to review and comment on.

We issued a press release about the TED to all national and healthcare trade broadcast, print and online media outlets, which resulted in coverage in the ‘Health Service Journal’ (HSJ), ‘National Health Executive’, ‘Commissioning Review’, and others. We also conducted an in-depth briefing on the TED with HSJ.

From early April 2014 we held six workshops and four webinars, reaching 1,648 people. On two occasions we sent promotional emails to around 4,000 organisations, including patient representative organisations and Royal Colleges before, during and after the TED consultation. The publications, workshops and webinars were promoted several times by various external partner newsletters and direct email. The TED and the methodology were posted on our website.

We sent 42 tweets that generated 757 clicks through to digital content, 134 retweets and replies reaching a potential of 565,000 followers. Eight updates on LinkedIn generated 189 clicks, potentially reaching an audience of 29,000. We had 77 responses to the methodology discussion paper and 414 responses to the TED.

Key stakeholder comments and our response can be found in Appendix B to this document.

1.1.2 Regional workshops

Workshops were held in Leeds, Birmingham and London, with 273 attendees from 160 organisations. Staff from NHS England and Monitor facilitated discussions about the proposed policy issues in the publications.

1.1.3 Webinars

We hosted four webinars to launch the publications. These helped to inform people who were unable to attend the workshops, and gave them the chance to give us feedback.

1.1.4 Other supporting activities

Opportunities for engaging with the sector were not limited to periods around the publication of important policy proposals. We met or spoke to people from several organisations to discuss our proposals in more detail and to listen to their ideas for the future of the payment system. These organisations were:

- Association of the British Pharmaceutical Industry
- British Medical Association
- Care Quality Commission
- College of Emergency Medicine
- Foundation Trust Network
- Health Finance Management Association
- The Health Foundation
- Muscular Dystrophy Campaign
- National Institute for Health and Care Excellence
- NHS Confederation
- NHS Partners Network
- NHS Trust Development Authority
- Orthopaedic Community
- Renal Care Community
- Richmond Group of Charities

- Royal College of Nursing
- Royal College of Obstetrics and Gynaecology
- Royal College of Physicians
- Royal College of Surgeons

1.2 Main themes from engagement

The main areas raised with us during the engagement activities were:

- our approach to transparency in our development and reasoning (most responders were supportive)
- understanding the effect of the proposals
- the design and impact of the efficiency factor
- the model used for national prices and the impact of particular draft prices
- the cost base used to calculate national prices.

This list is expanded with further information in Appendix C to this document.

1.3 Key stakeholders included in the engagement process

Monitor and NHS England formed a list of stakeholders for the national tariff engagement process from the parties likely to have an interest in and influence on the payment system. These are:

- national patient groups
- clinical commissioning groups (and commissioning support units)
- independent NHS healthcare providers
- NHS foundation trusts
- NHS trusts

- third-sector NHS healthcare providers

This does not include the one to one meetings which were also held.

Table 1: Summary of enagagement with sector stakeholders (not including one-to-one meetings)

Event	Foundation trusts	NHS trusts	Commissioners	Independent Providers	Other	Total
Acute workshops	34	10	29	14	15	102
Mental health workshops	16	5	27	18	23	89
Introduction webinar	44	29	73	43	321	510
In-depth webinar	33	24	35	29	223	344
Clinicians webinar	9	10	17	8	54	98
Total	**136**	**78**	**181**	**112**	**636**	**1,143**

Appendix A: Summary of responses to the '2015/16 National Tariff Payment System: national prices methodology discussion paper'

Responses	Our response
Process for price-setting policy changes	
1. What would you like to see from NHS England and Monitor to be confident that we are being transparent, evidence-based and consultative, and that we have assessed the impact of our proposals for the 2015/16 tariff?	
There were 69 responses Concerns were raised that: • Pricing methodology is only one piece of the puzzle. A number of stakeholders felt that there is a lack of clarity about the rest of the tariff • There is not enough signalling about Monitor and NHS England's long-term intentions for pricing, and how the proposals for 2015/16 help deliver this • Engagement does not happen early enough. Stakeholders would like engagement now on big changes for 2016/17. The maternity pathway was used as an example of a rushed policy that has had negative consequences • Transparency should be improved. For example, how were policies developed? What options were rejected? What was the evidence base? • There is a lack of clarity on how feedback influences decision-making • The impact assessment will not provide detailed enough information at a granula enough level for providers and commissioners to be able to understand how it affects them	• We have sought to provide more context in the National Tariff Engagement Document and the consultation notice • We have sought to be transparent on the reason for policies, including what evidence was used, what evidence was lacking, and (in the TED) what stakeholder engagement informed the proposals • We are developing a more comprehensive approach to the impact assessment and will continue to develop our approach for coming tariffs

Responses	Our response
Currencies	
2. Do you agree that Admitted Patient Currencies (APC) in 2015/16 tariff should be based on the 2011/12 reference cost design, rather than the 2010/11 design?	
There were 59 responses • There was general support for the proposed move to 2011/12 reference costs design as the basis for 2015/16 national prices • There was some push for HRG4+. In the absence of a move to HRG4+, stakeholders want engagement now about a future move to HRG4+ (which stakeholders appeared to expect to take place for the 2016/17 national tariff) • Some stakeholders want to see impact assessment to support the rejection of HRG4+ • There were some comments about the need to increase coverage (focus on high-spend areas) • Some responders expressed disappointment at the lack of new tariffs being proposed in the methodology paper (eg the Foundation Trust Network mentions previous discussions on outpatients tariffs)	• We have used 2011/12 reference costs design as basis for 2015/16 national prices • In the TED proposed additional new national prices, a new best practice tariff, and changes to existing best practice tariffs • We are reviewing the development of HRG4+ for inclusion in future tariff years
Approach to calculating national prices	
3. Do you agree with our preferred option of modelling national prices from updated cost data, rather than using a rollover approach? Please note that the decision must be consistent with the choice of currency design.	
There were 63 responses	

<table>
<tr><th>Responses</th><th>Our response</th></tr>
<tr><td>

There was general support for the proposed modelling of prices from costs (rather than a rollover approach)
A number of stakeholders wanted transparency about how model data translated into prices
Concerns were expressed that variations in prices due to the move from 2010/11 reference costs in the 2014/15 national tariff to 2011/12 reference costs for the 2015/16 national tariff would not be properly explained. Steps should be considered to mitigate changes (eg transition paths)
There were concerns that the tariff does not take new commissioning models into account
If and when we move to a new model, stakeholders want early engagement before the model comes into effect
There was some push for patient-level information and costing systems (PLICS) to validate/check prices

</td><td>

We are modelling prices from 2011/12 reference costs, rather than applying another rollover
Published pricing-setting models with the TED to provide transparency over how costs translate into prices
We have continued to engage with the sector on the updates to prices through existing Expert Working Groups and open consultation at the TED stage
We have outlined our approach to manual adjustments and accounting for substantial distribution changes in section 5
We are publishing local payment design examples that take into account good practice from within the sector that local areas can choose to adopt using a local variation

</td></tr>
<tr><td colspan="2">4. Do you agree with our preferred option of developing the Department of Health (DH) PbR 2013/14 model, rather than constructing a new model?</td></tr>
<tr><td>There were 61 responses

There was general support for updating the existing model

</td><td>

We modelled national prices using a refreshed tariff model, closely following the methodology used by the DH PbR team for the 2013/14 national tariff

</td></tr>
<tr><td colspan="2">5. Do you agree with our preferred option for updating the model inputs? Specifically:

a) applying more comprehensive data cleaning to the reference cost inputs to the model

b) using an average of reference cost data across several years, where appropriate (rather than using data for a single year)</td></tr>
</table>

Responses	Our response
c) **do you have any preference for any of the three options for updating short-stay emergency (SSEM) bandings?**	
Responses: • 5a) There were 57 responses • 5b) There were 58 responses • 5c) There were 53 responses • There was general support for enhanced data cleaning, but transparency is needed on what data is rejected and why • There was general scepticism about averaging reference costs – newer data was seen as better as it captures changing practices and allows better coding over time • There was general support for updating the bandings, either inputs or methodology • Stakeholders would like an opportunity to engage on any proposed change to methodology	• We are proposing to adopt most of the enhanced data cleaning rules on which we consulted • We modelled the proposed national prices on the basis of a single year of reference costs (2011/12) • We are proposing to adopt change to SSEM methodology and consulted on the methodology change in the TED
Cost adjustments to national prices	
6. What evidence would you want us to use in future years to be confident in our estimation of differential efficiency factors? Given current information constraints, do you agree with our preferred approach of estimating a single efficiency factor for 2015/16, based on data from the acute sector?	
There were 65 responses	

Responses	Our response
• There was general support for a single efficiency factor, given the lack of data and the complexity of differential factors approach • The exception was independent non-acute providers, who strongly rejected this option but did not offer an alternative • There was a strong push for clearer language in the national tariff and in guidance to commissioners on efficiency assumptions in local prices • It was thought that even if we cannot provide a reliable estimate of the efficiency factor for non-acute services, guidance in the tariff should recognise different cost structures of mental health/community care/ambulances and so on (eg by indicating a range rather than a single value) • It was felt there are issues with how the efficiency factor is interpreted for Cost Improvement Plans (CIP), double-counting with quality, innovation, productivity and prevention (QIPPS) and pass-through areas where savings are to the commissioner rather than the provider • There is a need to ensure that there is transparency in the evidence, assumptions and sensitivities tested when deciding the efficiency factor • Concern was expressed that there would be difficulty in selecting representative providers for bottom-up modelling • Some providers argued that an efficiency factor of 4% is too high	• We are proposing a single efficiency factor for 2015/16 • We have sought to clarify the intention behind the rule on setting and adjusting local prices, including that commissioners and providers could agree a different efficiency and cost uplift factors, and the types of information they should consider in doing so • We have published the Deloitte estimation report that we have used to inform the efficiency factor proposal, and sought to provide transparency about what judgement was used in coming up with the proposal • We are publishing an impact assessment alongside this consultation notice

<table>
<tr><th>Responses</th><th>Our response</th></tr>
<tr><td colspan="2">7. What might be the causes and drivers of leakage? What are the forms in which leakage might occur?</td></tr>
<tr><td>There were 56 responses

• There was a general view that leakage is really an umbrella term for several things, so may require different policy approaches

• Providers and commissioners generally agree that the main cause appears to be the tariff being considered too low, while at the same time there is political will to keep providers afloat

• Forms of leakage include block contracts, one-off payments, coding, prices lagging service changes and ‘noise’ in currency changes

• One specialist provider argued that one source of leakage was specialist providers making ’super-normal‘ profits on NHS England-commissioned services</td><td>• Leakage is the additional actions that providers or providers and commissioners take to protect or improve providers’ financial positions. We do not think that the term ‘leakage’ is helpful and in future our approach will be to focus on the components of the additional actions. There are several motivations for the additional actions including financial distress and negotiating power, and the components include approaches to income generation.</td></tr>
</table>

Appendix B: Summary of sector responses to the 'NHS National Tariff Payment System 2015/16: engagement documents'

Responses	Our response
National prices	
Draft national prices excel sheet	
There were 75 responses to the Draft national prices excel sheet • There are large price variations from the previous year for particular chapters • The reductions in the renal and orthopaedic chapter would affect service provision • Local authorities objected to the (non-mandatory) prices for sexual health services	• As part of the development of the final prices for the consultation notice we have engaged with a number of key stakeholder groups to understand their concerns. The final proposed prices reflect the adjustments that have been made in response to this engagement • We have looked at the response made to the TED on individual prices and have manually adjusted proposed prices if sufficient evidence has been presented to make such a change
1. Do you agree with our proposal to introduce new national prices for: **a. complex therapeutic endoscopy?** **b. dialysis for acute kidney injury?** **c. cochlear implants?** **d. transcatheter aortic valve implantation (TAVI)?**	
Responses and support for a new national price by category:	• We appreciate the desire for including services within national tariff where they are appropriately defined. However, we have also heard concern over the lack of prices in the TED for the sector to comment on. As a result, we intend to set non-mandatory prices for complex therapeutic endoscopy, dialysis for acute kidney injury and cochlear

Responses	Our response
• **Complex therapeutic endoscopy: 107 responses, 93% support** • **Dialysis for acute kidney injury: 94 responses,97% support** • **Cochlear implants: 78 responses, 97%support** • **TAVI: 92 responses, 90% support** Concerns were raised about the potential inclusion of the TAVI device in the proposed price as well as the lack of prices available during engagement for the sector to review.	implants for 2015/16 • Where we had set out a price for TAVI, it had been unclear whether the high cost device associated with this procedure was included in the proposed price or not. In clarifying that the device is on the high cost devices list, we intend to set a national price for the procedure.
2. Do you agree with our proposal to introduce a new best practice tariff (BPT) for heart failure that is based on one or more of the identified care processes?	
There were 112 responses, 92% support • Both commissioners and providers highlighted the need for a single accessible data source for monitoring purposes • Stakeholders sought more detail on the proposal and how it would be implemented, with providers mentioning lead-in times and implementation costs	• Following stakeholder feedback, data submission and specialist input were chosen for inclusion in the design of the proposed BPT. • Analysis of the national heart failure audit data indicates that on average 78% of patients currently receive input from a specialist during their admission; however, there is significant variation around the country. As a result, the achievement threshold for specialist input was set relatively low (at 60%) following stakeholder comments about the ‘run-in time’ for implementing the BPT • Reference cost analysis showed that trusts that provide specialist input for 60% or more of their patients may incur higher costs on heart failure services. We intend to investigate the reason of the cost differential further • We are proposing two prices per HRG (EB03H and EB03I). Providers not meeting the BPT criteria would receive the base price, which is

Responses	Our response
	90% of the full BPT price. Further guidance on the BPT has been provided in Annex 4a of the consultation document
3. Do you agree with our proposal to move to more ambitious thresholds on the Best Practice Tariffs (BPT) for: **a. hip and knee replacement?** **b. endoscopy procedures?** **c. operations to manage female incontinence day-case procedures?** **d. tympanoplasty day-case procedures?** **e. diagnostic hysteroscopy outpatient procedures?**	
Hip and knee replacement • **129 responses, 85% support** • Both commissioners and providers' comments focused on implementation issues (administrative burden, monitoring and so on) • Objections to the patient-reported outcome measures (PROMs) change were that this is outside the control of providers and a more detailed proposal is needed	• As feedback was positive about the proposed policy change, we propose that the BPT criteria for National Joint Registry (NJR) thresholds for both compliance and consent rates are increased from 75% to 85% in 2015/16
Endoscopy procedures • **121 responses, 83%support** • Some providers raised concerns about the capacity of the Joint Advisory	• Further discussions took place with members of JAG as well as providers and commissioners to determine the source of any delays in achieving accreditation that were not within the control of providers. JAG assured that there were no systematic delays from their

Responses	Our response
Group on GI Endoscopy (JAG) to undertake timely accreditation and update their website	perspective • In light of feedback from the TED, and the fact that the BPT has been in place for two years, we recommend changing the payment structure from April 2015 so that units achieving JAG accreditation level 2 will receive 97.5% of BPT price and units achieving JAG accreditation level 3 will receive 95% of BPT price. This would encourage providers that have achieved accreditation level 2 to continue to improve quality and safety of their endoscopy services
Female incontinence day-case procedures • **113 responses, 86% support** • Some providers raised the issue that the target was very ambitious, that there was no new funding for the BPT and that some patients would still not be suitable to be treated as a day case	• Based on TED feedback and data analysis on current activity levels, we are proposing that the threshold for operations to manage female incontinence will be changed from 45% to the target British Association of Day Surgery rate of 60% as set out in the TED
Tympanoplasty day-case procedures • **108 responses, 86%support** • Some providers said the gap between the current rate (45%) and the proposed rate (80%) was too big for a single-year jump	• In light of feedback from the TED we are proposing that the threshold will be changed to 65% in 2015/16. The intention is to complete the transition in 2016/17, when HRG redesign may have addressed some of the concerns raised
Diagnostic hysteroscopy • **112 responses, 88% support** • Some providers and commissioners were concerned that the target may be	• In light of feedback from the TED we are proposing that the threshold for diagnostic hysteroscopy procedures will be increased from the current transition rate of 60% to 70% in 2015/16, with the intention of

Responses	Our response
too high in one year	completing the transition in 2016/17 to 80%
4. Do you agree with our proposal to add six factors to the maternity pathway currency, to improve allocations?	
There were 110 responses, 79% support • 20% of CCGs and approximately 25% of providers rejected the proposal • Both commissioners and providers sought clearer definitions and better guidance • Providers' comments focused on the level of the tariff that they say underfunds the cost of service, and on cross-provider charging (administrative burden)	• We note most respondents supported the additional factors and we are proposing this change. • We published supplementary guidance to help providers with implementing the maternity pathway payment system in August 2014 • We are providing more guidance on the definitions of the factors which determine the pathways in Annex 4b which accompanies this document
5. Do you agree with our proposed additions to the high cost drugs list?	

There were 135 responses, 85% support
 	
• Providers and commissioners want a more strategic approach to reducing the size of the list, particularly as some drugs are included in routine treatment
• Requests for new additions and comments on specific drugs
	• We have listened to the comments received through the TED, particularly concern around the length of the list. With advice from the High Cost Drugs Steering Group, we:
	    ○ have reviewed the proposals for most recent information, removing drugs which are no longer likely to come to market in 2015/16
	    ○ have reviewed the list of 'Drugs used in Metabolic Disorders', resulting in some drugs being removed from the list, when they are used for other conditions
	    ○ have reviewed the specific suggestions for additional drugs for

Responses	Our response
	the list ○ are also considering how to reduce the size of the high cost list for future tariffs
6. Do you have any views on how we should identify the appropriate cost level on which to set prices, including which costs, if any, should be stripped out of the reference costs used to model national prices?	
• **There were 33 responses to this question** There were some differences of opinion between providers and commissioners Commissioners generally wanted: • some costs such as research income and catering costs stripped out • special funding arrangements such as winter planning and resilience funding separated • non-recurrent costs such as transitional costs or temporary capacity boosts to be excluded Providers generally felt: • there was no case to strip out further costs unless there was greater evidence of need or that they were replaced • that stripping out further costs would lead to trusts seeking to recover those costs elsewhere • that winter pressure funding should not be stripped out as it is recurrent	• We considered reported 2011/12 reference costs and evidence on the types of adjustments we might need to make. We concluded that it was not possible to accurately identify and quantify an appropriate set of cost adjustments in the time available to develop proposals for the 2015/16 national tariff. • The proposed approach for the 2015/16 national tariff is to reconcile prices to the level of expenditure that would have been achieved if 2014/15 national prices were used. • While the cost base (and therefore price levels before the application of the efficiency and cost uplift factors, or any smoothing adjustments) reflects expenditure under 2014/15 prices, price relativities – differences in prices relative to one another – are based on prices modelled from 2011/12 reference costs
7. Do you have any comments on the proposed data cleaning rules, and the proposed process for manual adjustments to modelled national prices?	

<table>
<tr><th>Responses</th><th>Our response</th></tr>
<tr><td>There were 29 responses to this question
Of those organisations that responded the key points were:
data cleaning was broadly supported
greater transparency was needed when conducting it
the impact on specialist trusts was not disproportionate if they were managing outliers
the £50,000 removal rule was inappropriate</td><td>We are proposing removal of two rules: the £50,000 exclusion rule and the illogical relativity exclusion rule
There are more details of these exclusions within Section 5</td></tr>
<tr><td colspan="2">8. Do you agree with our proposed changes to the SSEM bands and eligibility?</td></tr>
<tr><td>There were 104 responses, 85% support
Broad agreement to update bands and eligibility to be consistent with 2011/12 reference costs
More detail was needed for a number of providers to be able to make a judgement</td><td>We have updated the data used in the SSEM calculation by using reference costs from 2011/12</td></tr>
<tr><td colspan="2">9. Do you agree with our proposals to retain the previously used approaches for indexing costs up to the tariff year, and for setting the cost uplift factor?</td></tr>
<tr><td>There were 150 responses, 77% support
Concerns were raised over the increasing gap between actual costs and the use of projections of historical figures
Cost uplifts do not account for, and therefore do not encourage, innovation such as seven-day working</td><td>We will continue to use the 2013/14 PbR method which includes a number of components to address some of the areas of changing complexity over time</td></tr>
</table>

Responses	Our response
• Clinical Negligence Scheme for Trusts (CNST) should be specific to trusts so that some are not penalised	
10. Do you agree with our proposed process for coming up with any service development uplift?	
• **There were 148 responses, 74% support** • Stakeholders want greater clarity about the proposed process. • Stakeholders requested greater transparency about the calculation. • Several providers requested that it should include 7-day working and the delivery of the recommendations under the Francis and Keogh reports.	• In the event of a service development uplift being identified we will engage with the sector on what is to be applied and how it is to be applied
11. Bearing in mind our proposed range of 3-5%, what do you think the efficiency factor applied to national prices in 2015/16 should be?	
• There were 45 responses to this question • Commissioners generally favoured a factor of 4% or higher, while most providers favoured a 3% factor or lower • Commissioners' comments focused on affordability, but some argued for a 3-3.5% factor on the basis of provider viability. Some argued that leakage should be considered when setting the efficiency factor • Providers' comments focused on financial viability. Some comments were based on a misinterpretation of the Deloitte work as pointing to a 2.2-2.7% efficiency factor. • NHS Confederation expressed concern that the factor was being used as a balancing item to ensure affordability. Similarly, some providers suggested that 3-5% was not evidence based and conflated efficiency with affordability • Non-acute providers highlighted application of factor to local prices	• The efficiency factor requires us to exercise a significant degree of judgment. In doing this we considered evidence from an independent study we commissioned to provide an evidence base for our decision. We interpreted this evidence as revealing that, based on historical performance, the sector can achieve a maximum of 4% in an average year. • Setting an efficiency factor at the top of the possible range tasks providers with answering the financial challenges of 2015/16 through an extraordinary effort. On the other hand, we also considered recent performance by providers that suggests that achieved efficiency savings may be decreasing. • We are proposing an efficiency factor of 3.8%. • Although this is a lower efficiency factor than in recent years, we consider it to be challenging but also achievable. This efficiency factor

Responses	Our response
regardless of the providers' current level of efficiency, and to block contracts in the absence of volume adjustments	reinforces the need for providers to work hard in continuing to strive to deliver high quality care at lower cost. • We also believe that decreasing the efficiency factor from the that set out in the 2014/15 national tariff, reduces the risk of efficiency targets not being met. Subsequently, the likelihood of the efficiency factor putting pressure on provider finances and the risk of adverse impact on the quality or safety of services are also reduced. In addition, we considered that the financial pressure could be further eased through other actions by providers and commissioners.
12. What do you think are the appropriate policy measures to address any undesirable 'additional actions' that are potential sources of leakage?	
There were 36 responses to this question • **Both commissioners and providers generally were against having a 'leakage factor'** • Stakeholders generally considered that more needs to be done to understand and explain leakage • Stakeholders generally considered that forms of leakage that are not in patients' interest should be singled out and addressed specifically, particularly through local solutions • Providers, including independents, pointed to wide variation among providers in their ability to engage in leakage	• We are not proposing to include a separate leakage factor in the national tariff. Instead we will address leakage through policies that increase transparency, accountability and rigour in coding and counting. • Where appropriate, Monitor will be initiating coding enforcement and compliance investigations. As part of the wider enforcement and compliance programme Monitor will be undertaking work to ensure that local variations are compliant with the National Tariff rules. Commissioners are already required to notify Monitor of all local variations to national prices. Commissioners and providers will be asked to take actions to rectify non-compliance with the national tariff. • NHS England will shortly consult on draft changes to the NHS Standard Contract for 2015/16 including notice period requirements on proposed changes to counting and coding and the management of financial impacts in relation to these. NHSE intends that these changes combined with requirement to report local payment variations, will promote financial stability as well as greater transparency.

Responses	Our response
National variations	
1. Do you agree with our proposal to remove the national variation for the maternity pathway payment?	
There were 100 respondents, 74% support • There was general concern over the quality and flow of data • There were provider concerns over implementation	• We note most respondents support the removal of the national variation for the maternity pathway payment and therefore are proposing this change • The Health and Social Care Information Centre has confirmed that it will be able to receive and process the new Maternity Data Set from April 2015. We believe that this will have a positive impact on the quality of data
2. Do you agree with our proposal to remove the national variation for the unbundled diagnostic imaging in outpatients?	
There were 126 responses, 86% support • **While there was a feeling that two years was sufficient for implementation some commissioners and providers felt this should be longer** • A number of variations remain in counting, coding, and service models	• We note the majority of respondents support the removal of the national variation for unbundled diagnostic imaging in outpatients and therefore are proposing this change • Whilst some concerns were raised about whether enough time had been allowed for transition, we feel that there has been sufficient time for the NHS to adapt. Where there are exceptional circumstances which mean this rule is not appropriate, providers and commissioners can use local variations
3. Do you agree with our proposal to remove the national variation for chemotherapy delivery and external beam radiotherapy?	
There were 93 respondents, 76% support • The national variation may be the most cost effective option if there is a requirement for capital investmen • There were some concerns that two years was not long enough to embed	• We note that most respondents agree with the proposed change and therefore are proposing this change. • While again there were concerns that there had not been enough time for transition, the 2014/15 national tariff document informed organisations they ‘must move further towards national prices’, which

Responses	Our response
practice	should mitigate any potential negative impact from this change. • Where this causes difficulty, providers and commissioners can agree local variations
Local prices	
1. Do you think our proposed guidance on applying the rules will sufficiently clarify for commissioners and providers how to develop local payment arrangements for mental health services?	
There were 70 responses, 59% agreement • While over half agreed that the guidance provided sufficient clarity, respondents wanted more clarity regarding how to align actions with policy expectations in practice • Concern was raised over the quality and robustness of cost, activity, quality and outcome data submitted by the sector – needed to support commissioner understanding of costs and facilitate payment negotiations • There was some concern that transition to new payment models may cause financial destabilisation of local health economies • There is a need to draw out the importance of coordination and parity between metal health, physical health and community services	• We have taken this feedback into account in our revisions to the guidance to address the concerns of commissioners and providers.
2. Would the planned topics and content of the proposed payment examples help you to make more effective use of local payment arrangements to support the changes you are planning to make to respond to the short-term and long-term challenges?	
There were 130 responses, 75% agreement. • Publishing examples is generally supported by stakeholders, but stakeholders are also seeking more detail on the proposals before they can	• Overall the feedback was supportive of publishing LPEs, so we will go ahead and do so • We used the feedback received to directly change the LPEs that we

Responses	Our response
determine whether they should be using them. • Providers were strongly against the marginal rate example and typically did not favour the integrated outpatient example. Some commissioners called both examples unnecessary or not workable. • Stakeholders consider local examples might not be appropriate in a national setting, and that we would need to demonstrate a sound evidence base before contemplating national roll out or switching default positions.	will publish with the 2015/16 docs. For example, not taking forward the integrated outpatient tariff and the marginal prices for inpatient elective care in 2015/16 • We also decided not to have separate LPE on personal health budgets • Using the feedback, we will ensure that the LPEs are drafted to be clearly for local arrangements to support local initiatives
3. What benefits and costs do you see from making the approaches used in the payment examples the default national payment approach potentially from 2016/17?	
There were 27 responses to this question • There was a general feeling that 2016/17 is too soon • Up-front investment would be needed to offset the costs of transition and transformation • Community clusters need to be developed as a matter of urgency	• We will make clear in drafting that the LPEs are for local arrangements to support local initiatives at this stage. We will take care to critically assess evidence from the local examples, and undertake rigorous impact assessment, before any decisions are made about potential switching of defaults to the proof-of-concept approaches • We are going ahead with the publication of the community assessment and care coordination currencies payment example for 2015/16 as part of wider community currency clusters development
4. How can we strengthen guidance to support local negotiations so as to ensure that local prices reflect efficient costs?	
There were 36 responses to this question • Stakeholders mainly highlighted issues around lack of data • Both commissioners and providers sought clarity on the role of information from outside the national tariff when setting local prices. For commissioners, this mainly related to use of benchmarking. For providers, this mainly was about commissioners being required to take into account data the provider	• In the proposed local price-setting rules, we have added guidance that clarifies the intention of Rule 2 . This stresses that commissioners and providers may agree to make price adjustments that differ from the overall price adjustments included in the national tariff where there are good reasons to do so and it is in the best interests of patients • We have also listed the types of evidence that could be used to inform

<table>
<tr><th>Responses</th><th>Our response</th></tr>
<tr><td>supplies

• Both commissioners and providers sought examples of best practice local negotiations, including templates and suggested timelines

• Providers wanted guidance on acceptable margin levels, and that reflecting indirect costs in local prices

• Commissioners sought guidance on how to adjust multi-year contracts</td><td>local negotiations</td></tr>
<tr><td colspan="2">5. How well would each of the options achieve the policy goal of promoting value for patients from payments for services without national prices and accelerating convergence to prices that reflect most efficient costs? What issues would need to be considered in implementing each option?</td></tr>
<tr><td>There were 29 responses to this question

• Both commissioners and providers generally preferred guidance to a rule

• Some commissioners feared that negotiations regarding baselines and growth rates might still be onerous

• Many stakeholders stated that we have not made a strong enough case that there was an issue, nor explained what was driving it

• Stakeholders also highlighted concerns about the lack of quality data to compare with different costs of care, and a lack of acknowledgement about why efficiency in service delivery may vary naturally</td><td>• The description of local negotiations, good and bad, shared by commissioners and providers is informing the guidance we will produce on the hall marks of good local negotiation. This includes how some local areas are working to overcome data limitations and the responsibilities commissioners have to monitor quality

• The points raised about the possible inconsistency in policy design between a rule on payments for non tariff acute services and encouraging use of local variations to enable service innovation, has led us to refine our policy focus to specialised services commissioned by NHS England only

• The consensus from stakeholders that any policy change should be simple and not increase transaction costs supports the design of the proposed rule for 50:50 gain and loss sharing (not marginal rates)</td></tr>
<tr><td colspan="2">Enforcement</td></tr>
<tr><td colspan="2">1. Do you agree with our proposed guidance on the submission of information in relation to local payment arrangements? Specifically:</td></tr>
</table>

<table>
<tr><th>Responses</th><th>Our response</th></tr>
<tr><td colspan="2">a. on a proposed date for submitting local modifications to Monitor

b. on the inclusion in local modification submissions of details of plans to address structural issues

c. for publishing decisions to refuse local modifications, as well as approvals

d. for the inclusion in local variation submissions of information relating to measuring the benefits of the variation and on non-recurrent costs of redesigning and restructuring services.

e. on recording information about local pricing</td></tr>
<tr><td>1a) There were 133 responses, 73% support

1b) There were 128 responses, 83% support

1c) There were 137 responses, 85% support

1d) There were 133 responses, 83% support

1e) This question was not included in the TED survey

• Some concerns were expressed over the administrative burden

• There is a belief that publication would bring transparency

• Concern was expressed about sharing commercially sensitive information</td><td>• The feedback from the sector supported increasing levels of transparency. We are going to continue to look at ways that we can present the data provided by the sector in a way that enables providers and commissioners to learn from good practice

• We are also looking at ways to better align our requirements to standard commissioning and contracting practice in order to reduce the administrative burden on commissioners and providers</td></tr>
<tr><td colspan="2">2. Do you think that any of the proposed changes in question 1(a) (b) or (e) should by made mandatory by a change to the method for local payments, rather than being set out as guidance?</td></tr>
<tr><td>There were 124 responses, 36% support

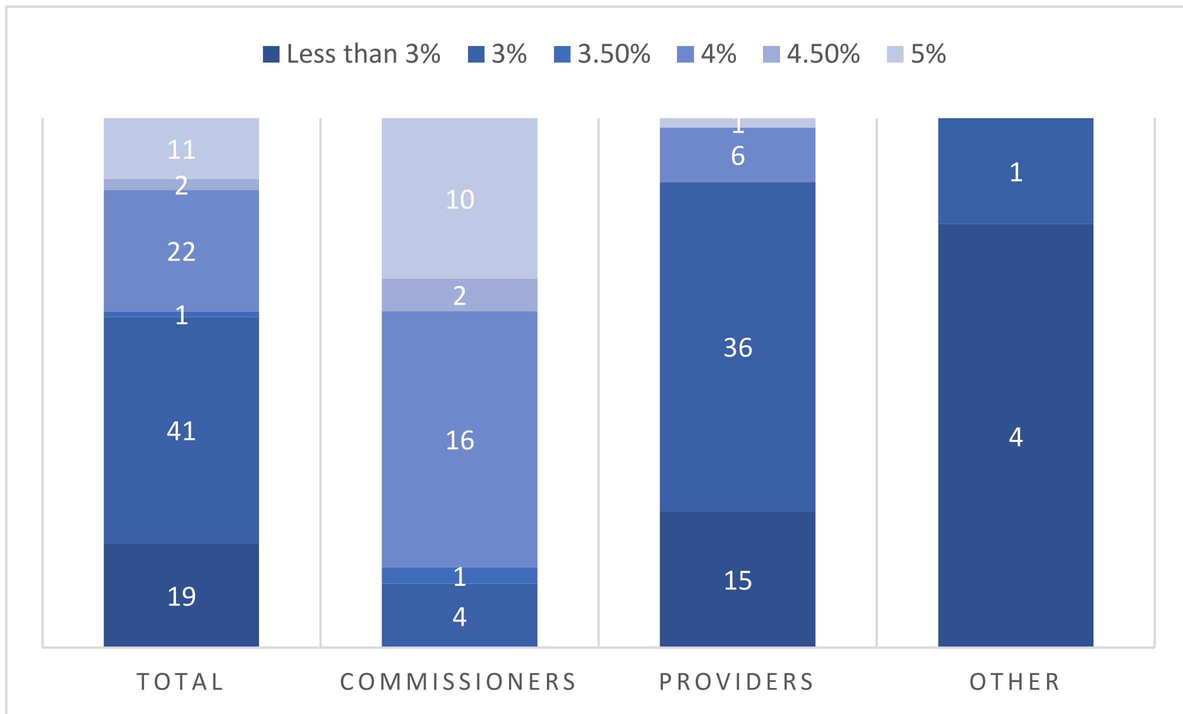
• It was generally felt that mandating these changes should be a long-term change</td><td>• Following feedback from the sector we will not expect providers to submit information on local prices without a national currency except where it is required for enforcement and compliance purposes

• We propose 30 September 2015 as the guideline submission date for</td></tr>
</table>

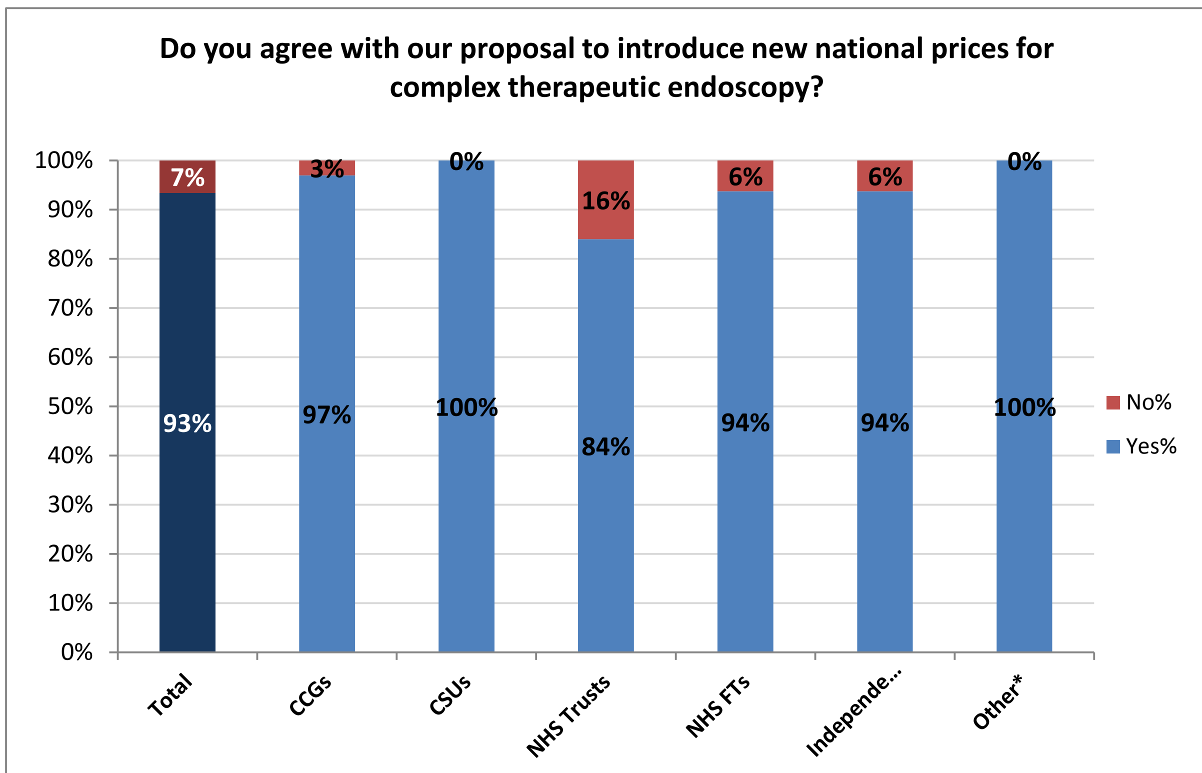
Responses	Our response
• It is thought that guidance and practice is still not well enough understood or embedded by the sector	local modifications responses but we will still review applications submitted after this date • We propose publishing the local modifications that are rejected as feedback highlighted the importance of transparency • We will expect commissioners to include information relating to the benefits of variations and non-recurrent costs of service transformations. This data should be available as part of the normal contracting and commissioning process • We will expect providers to include plans to address structural issues in relations to local modification applications so that they can demonstrate how they will return to tariff
Other questions	
1. Do you think that any of the proposals in the engagement documents (individually or collectively) will have an impact (whether positive or adverse) on persons with 'protected characteristics' under the Equality Act 2010?	
There were 121 responses, 20% believed the proposals would have an effect on people with protected characteristics • Many respondents felt it was very difficult to tell • Some highlighted the effect of reductions in renal tariffs on black and minority ethnic group communities, as they are disproportionately affected by renal failure • Some non-acute trusts highlighted the impact of the efficiency factor on people with mental health conditions	• We conducted an analysis of the impact our proposals on people with 'protected characteristics' under the Equality Act 2010 as part of our Impact Assessment • To improve the transparency of the impact of national price changes on protected groups, we are planning to include data on sex, age and ethnicity in our Tariff Engine. This should allow us to identify disproportionate impacts on specific groups from changes to national prices or currencies • We are updating our model to incorporate BPTs, which should allow us to see the a) the impact of changes to the renal tariff and b) the

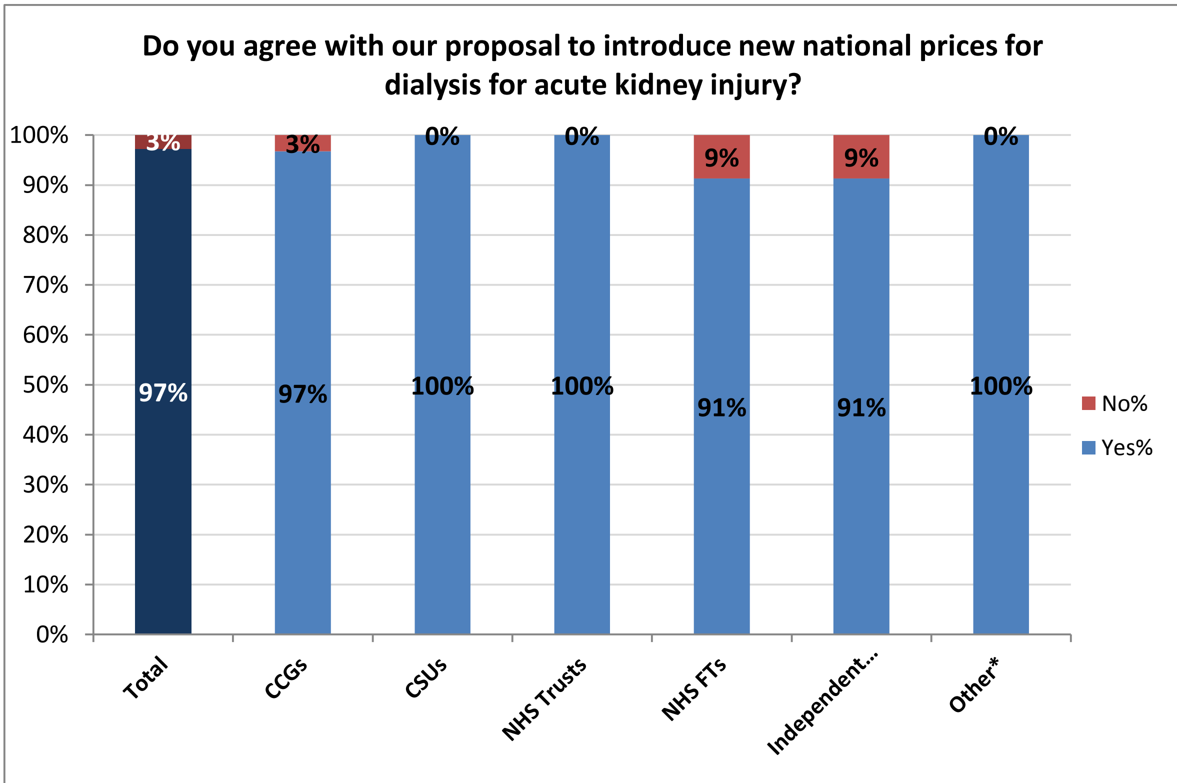
<table>
<tr><th>Responses</th><th>Our response</th></tr>
<tr><td></td><td>impact specifically on BME groups (based on 2012/13 activity data)</td></tr>
<tr><td colspan="2">2. Do you foresee any information governance issues arising from the proposals in this document?</td></tr>
<tr><td>There were 142 responses, 31% foresaw information governance issues
• Several data issues were identified in relation to the increased amounts of data that some TED proposals would require
• Commissioners had concerns about tracking patients for risk stratification and payment purposes
• Some providers had issues in sharing data effectively between themselves</td><td>• We will continue to review proposals in light of the concerns over information governance
• We are working with pioneer sites to address issues of information governance issues with the development of new payment approaches</td></tr>
<tr><td colspan="2">3. Do you have any further comments on the matters raised in this document?</td></tr>
<tr><td>There were 34 responses to this question
• There was too much information and too little time to absorb and respond in the consultation period
• Change needs to be at a pace that does not destabilise the sector.
• The Market Forces Factor needs to be revised
• Several providers complained about the lack of revision to the Marginal Rate Emergency Tariff
• Simpler documentation would be welcome – one document with everything in it, simpler and clearer language
• There should be changes to the web form to give users better functionality</td><td>• As part of our long term planning we intend to review all of the policies within the national tariff
• We are looking to dramatically improve the accessibility of the information that we produce over time including the way that we produce documents and the forms that we ask stakeholders to complete. We are looking at ways to engage members of the sector to support this</td></tr>
</table>

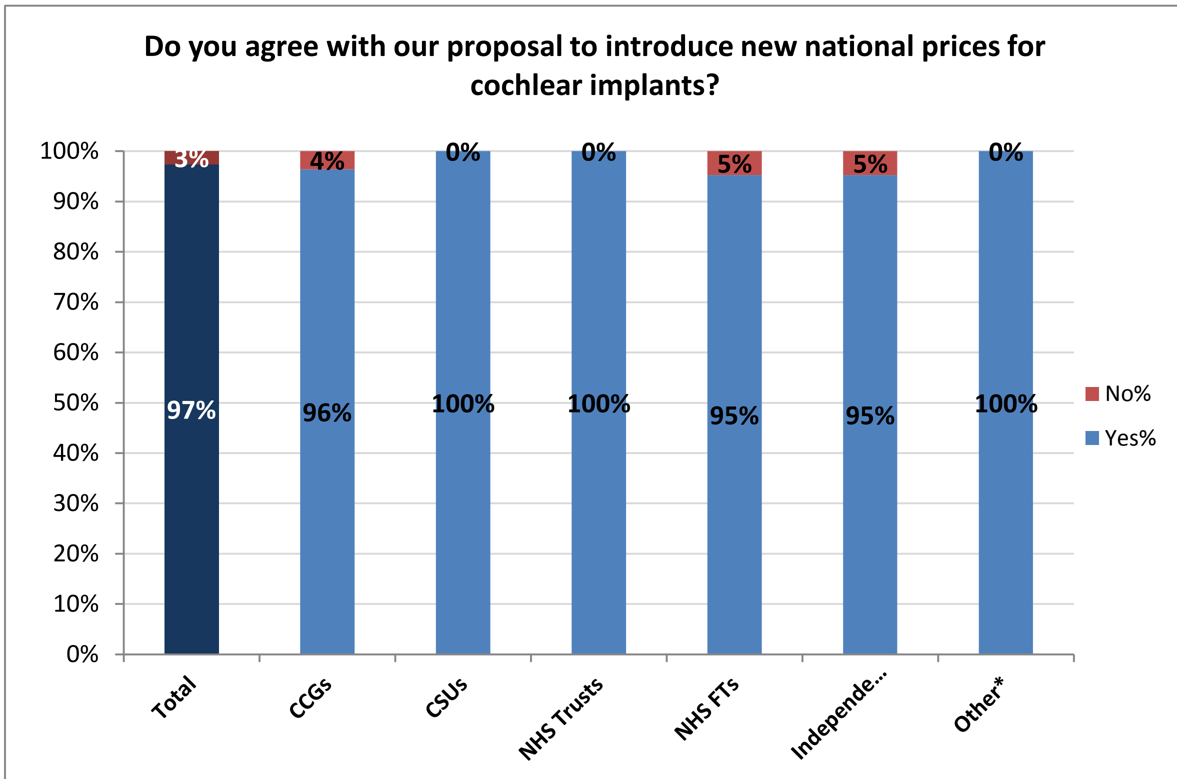
Appendix C: Statistical summary of responses



Note: Where the response was in the form of 'no higher than x%' or 'at least x%' we used the figure quoted.




Do you agree with our proposal to introduce new national prices for dialysis for acute kidney injury?
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
3%
97%
3%
97%
0%
100%
0%
100%
9%
91%
9%
91%
0%
100%
No%
Yes%
Total
CCGs
CSUs
NHS Trusts
NHS FTs
Independent...
Other*


Do you agree with our proposal to introduce new national prices for cochlear implants?
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
3%
97%
4%
96%
0%
100%
0%
100%
5%
95%
5%
95%
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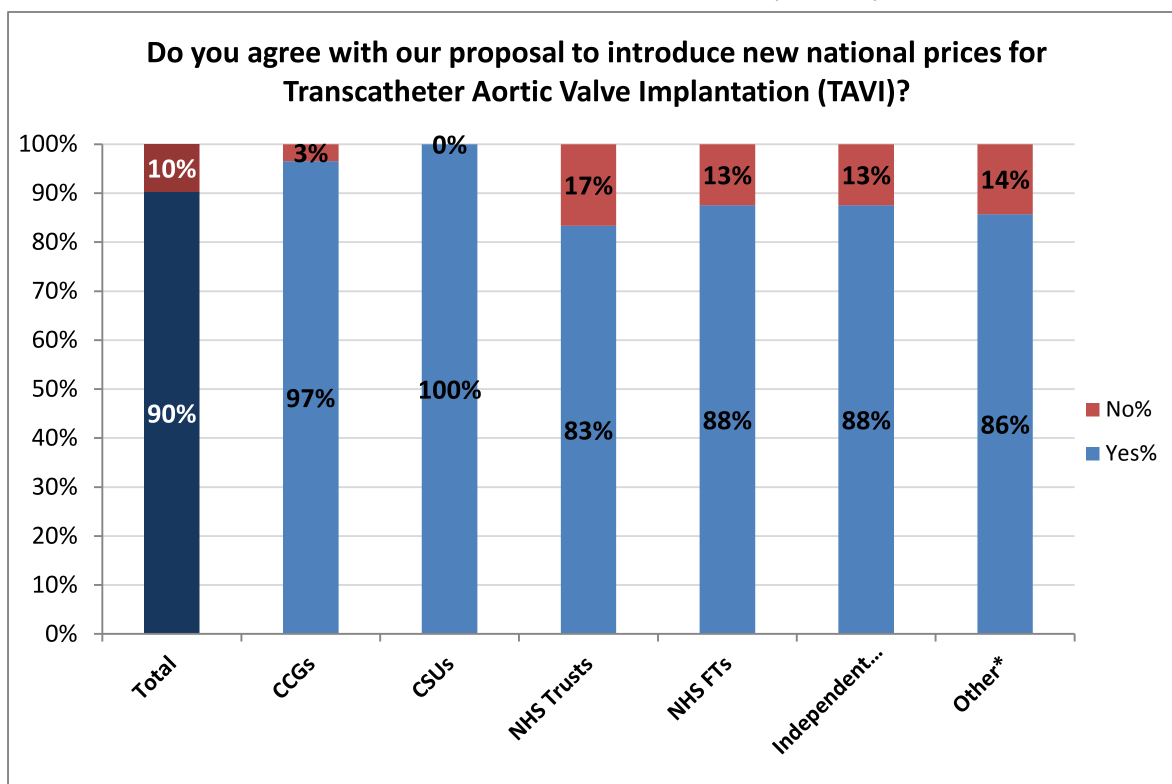
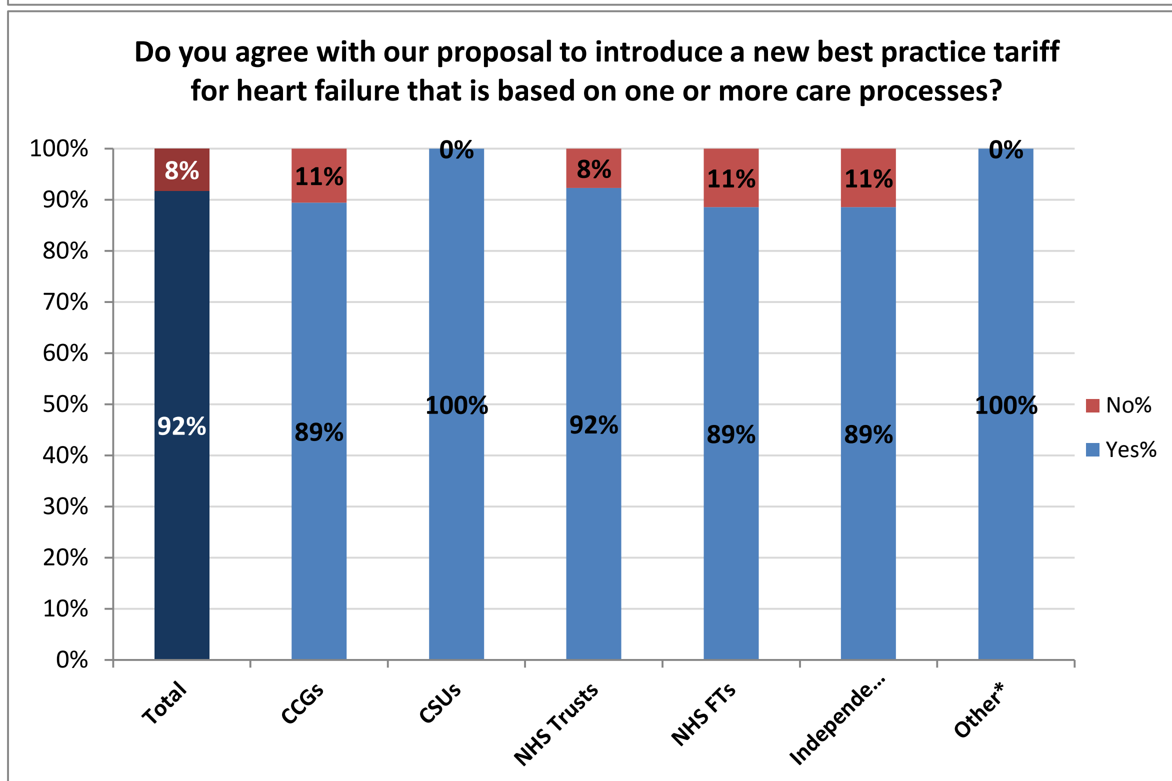
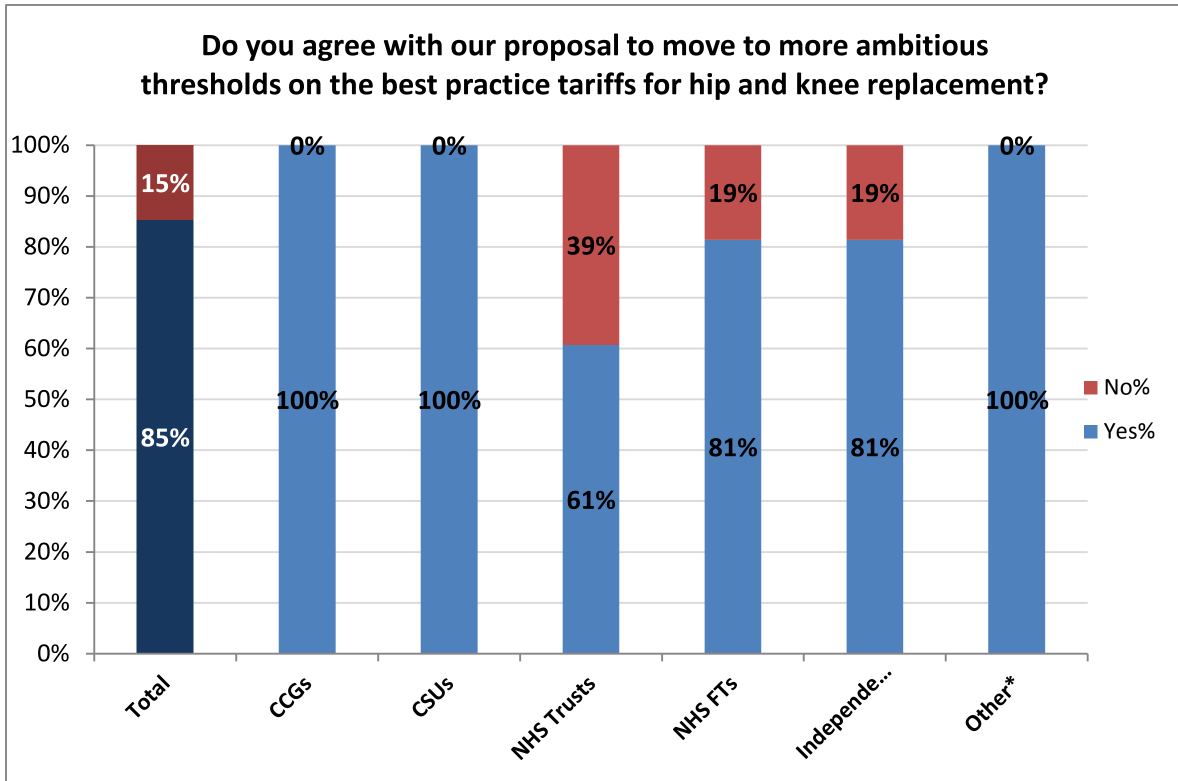
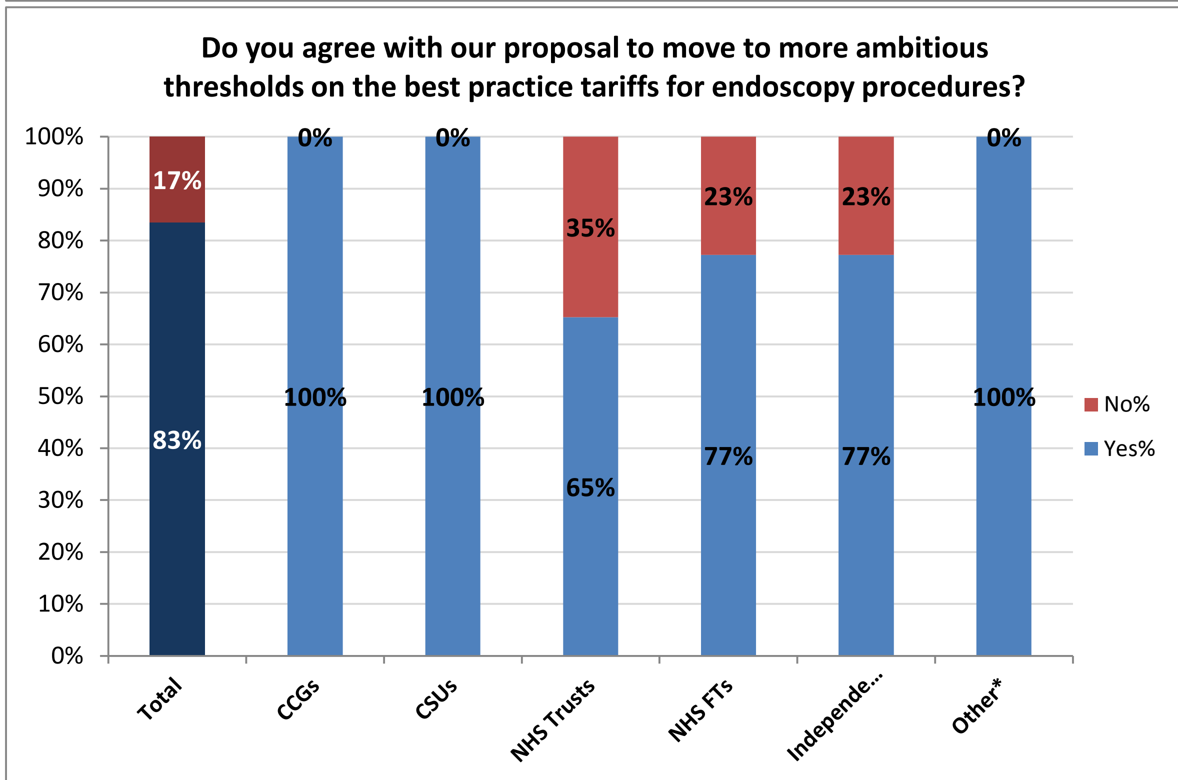
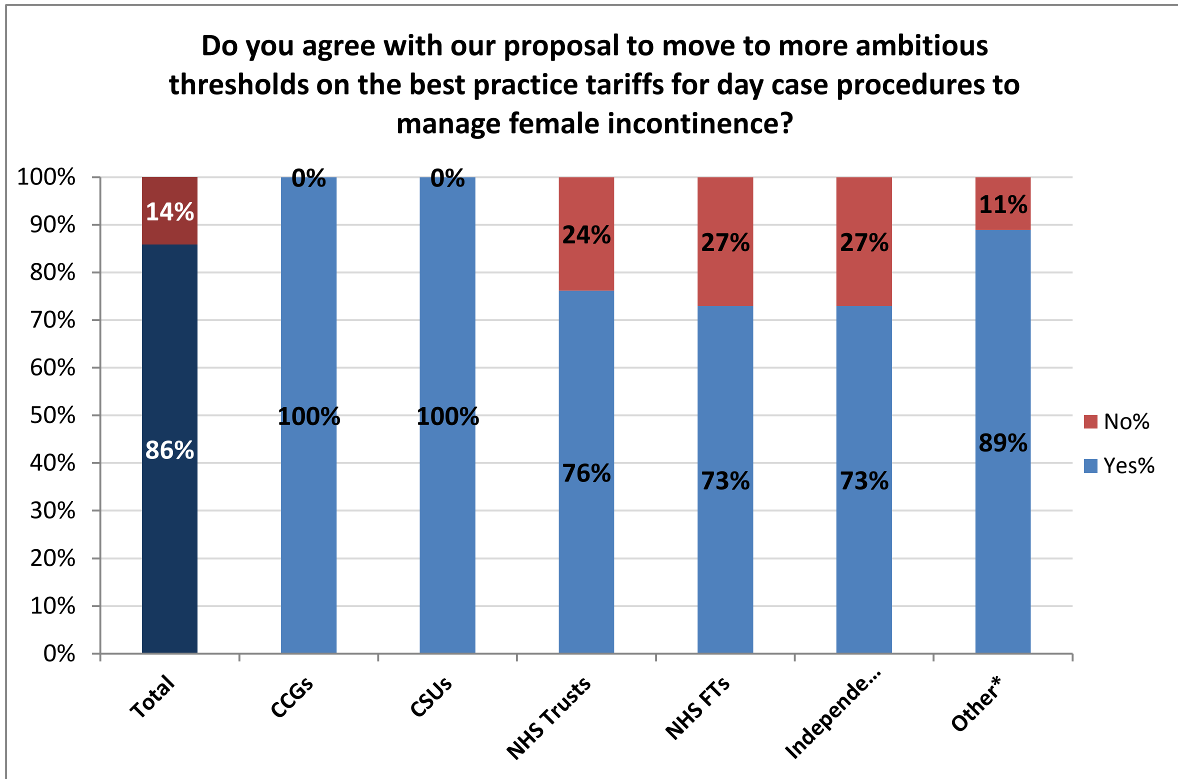
100%
No%
Yes%
Total
CCGs
CSUs
NHS Trusts
NHS FTs
Independe...
Other*

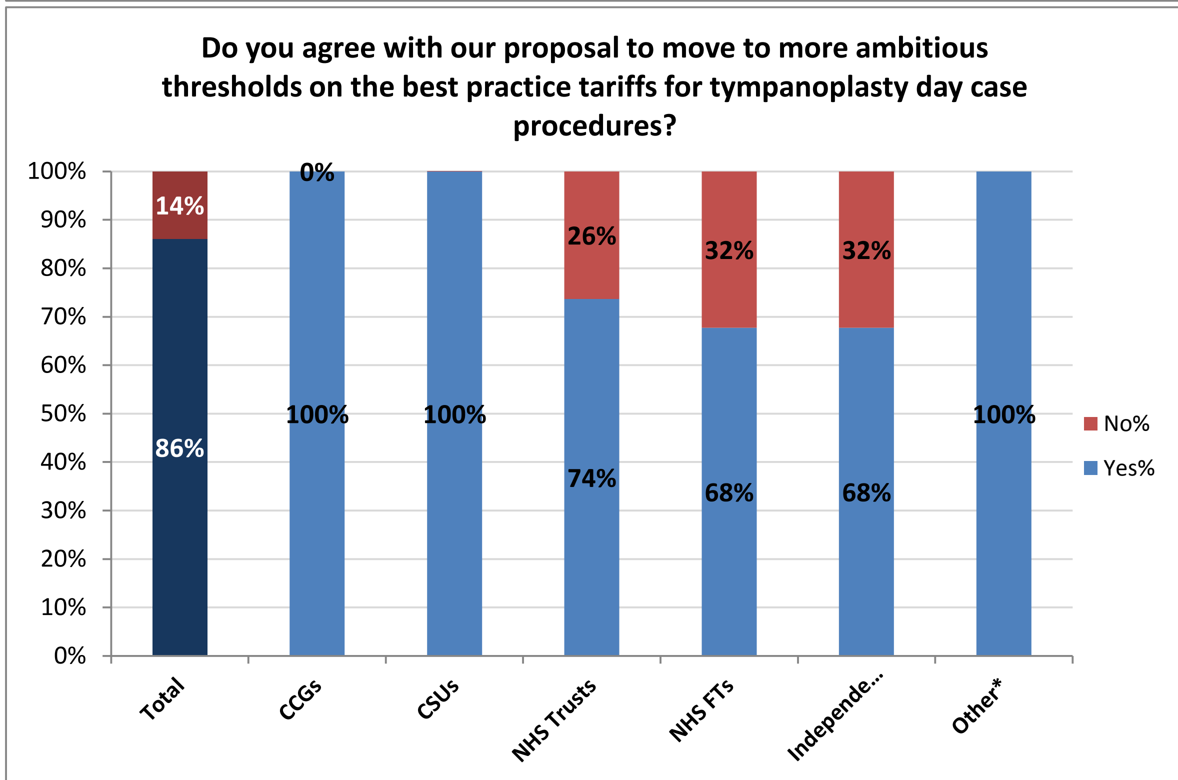

Do you agree with our proposal to introduce new national prices for Transcatheter Aortic Valve Implantation (TAVI)?
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
10%
90%
3%
97%
0%
100%
17%
83%
13%
88%
13%
88%
14%
86%
No%
Yes%
Total
CCGs
CSUs
NHS Trusts
NHS FTs
Independent...
Other*

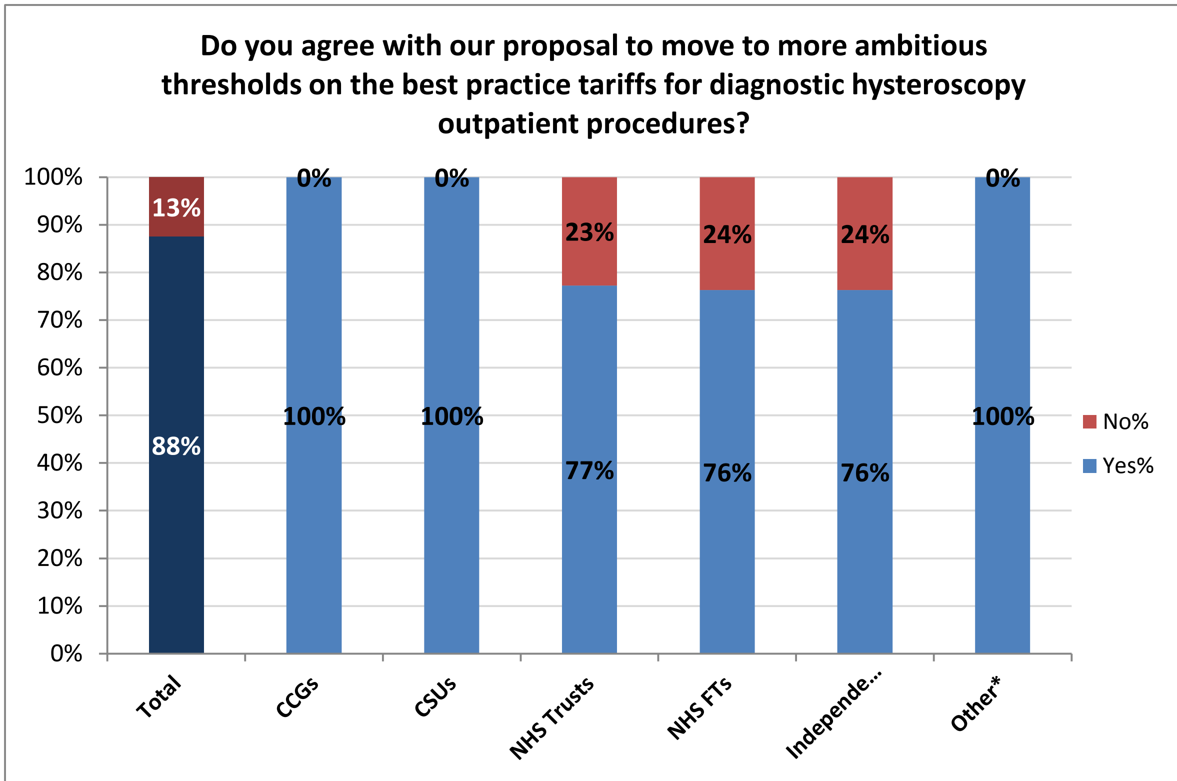

Do you agree with our proposal to introduce a new best practice tariff for heart failure that is based on one or more care processes?
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
8%
92%
11%
89%
0%
100%
8%
92%
11%
89%
11%
89%
0%
100%
No%
Yes%
Total
CCGs
CSUs
NHS Trusts
NHS FTs
Independe...
Other*

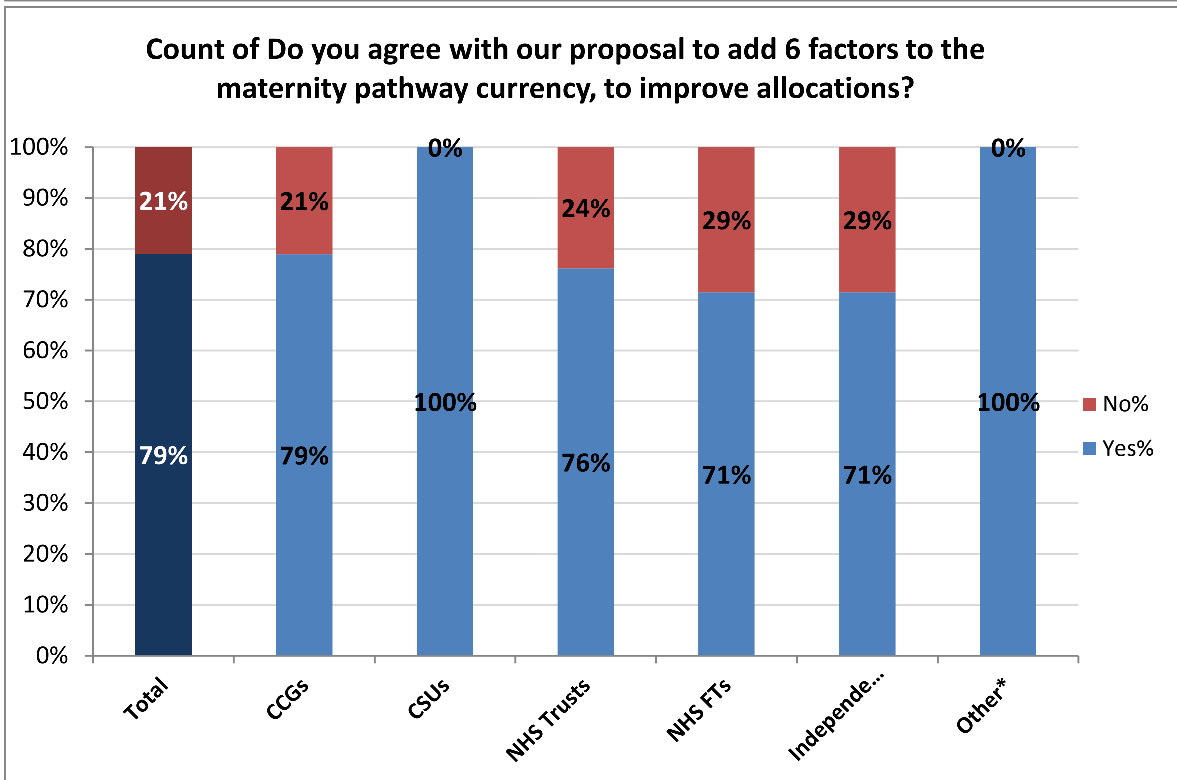

Do you agree with our proposal to move to more ambitious thresholds on the best practice tariffs for hip and knee replacement?
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
15%
85%
0%
100%
0%
100%
39%
61%
19%
81%
19%
81%
0%
100%
No%
Yes%
Total
CCGs
CSUs
NHS Trusts
NHS FTs
Independe...
Other*

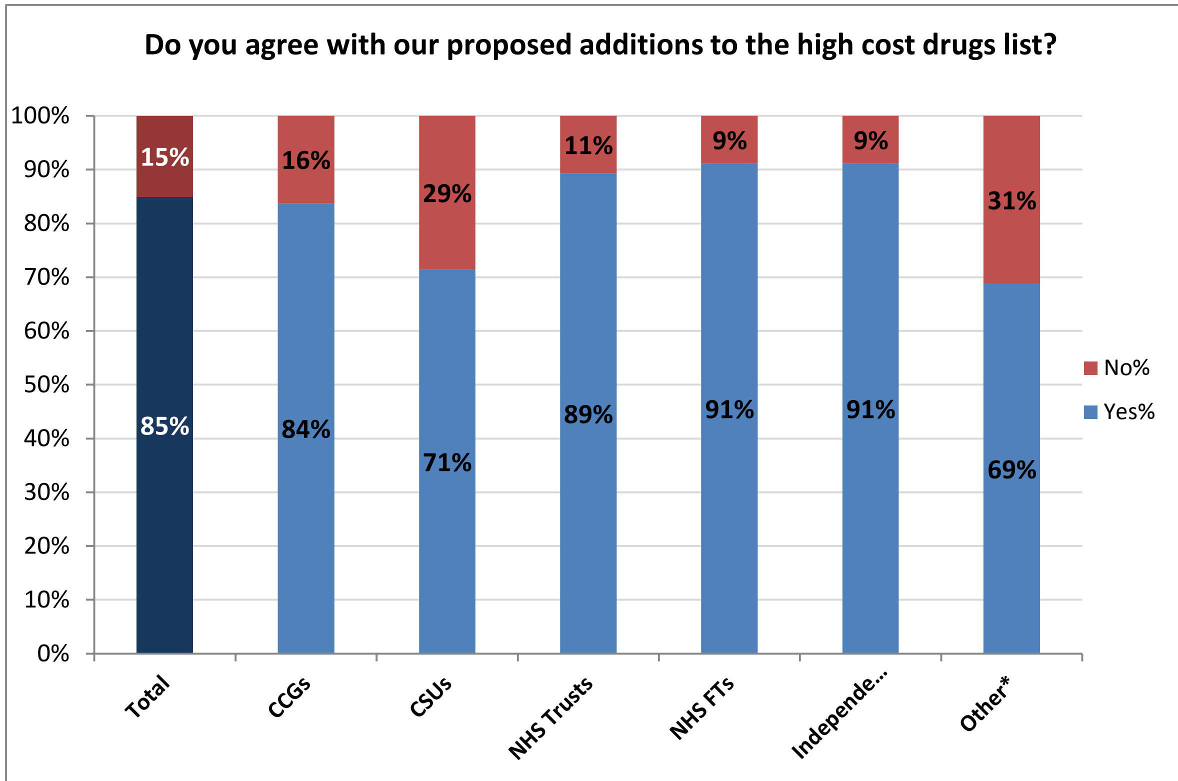

Do you agree with our proposal to move to more ambitious thresholds on the best practice tariffs for endoscopy procedures?
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
17%
83%
0%
100%
0%
100%
35%
65%
23%
77%
23%
77%
0%
100%
No%
Yes%
Total
CCGs
CSUs
NHS Trusts
NHS FTs
Independe...
Other*

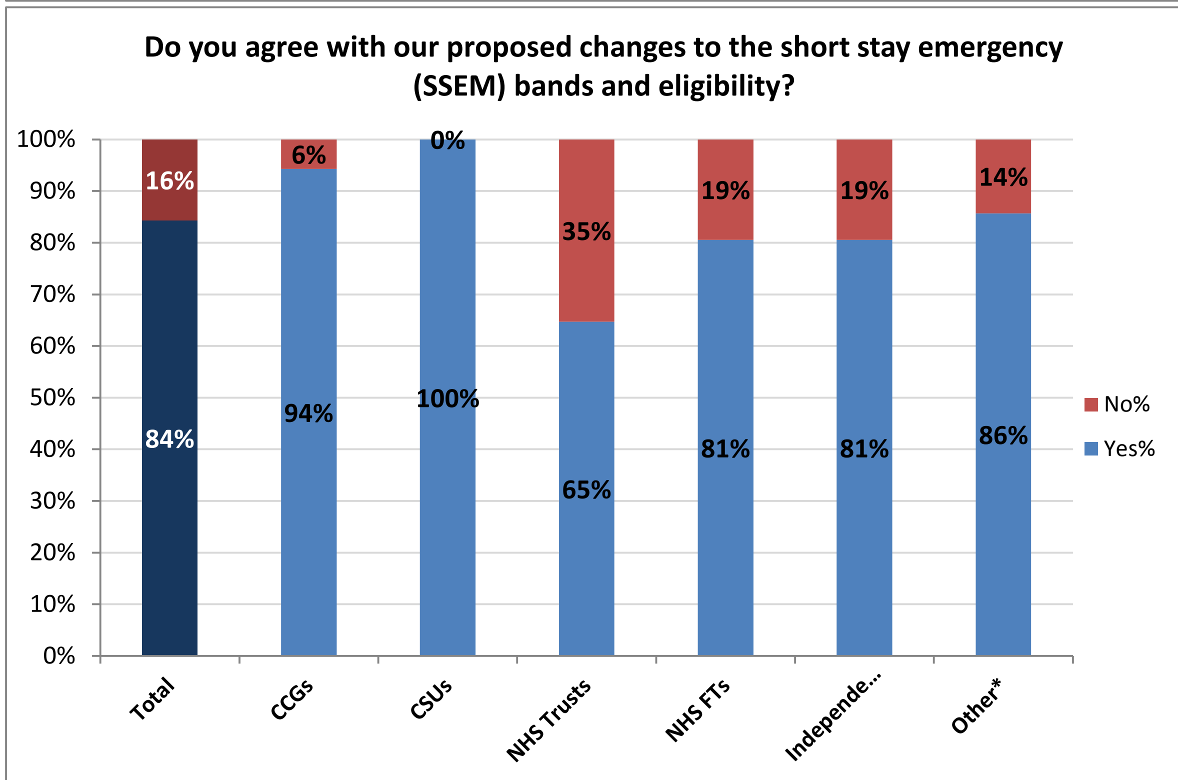

Do you agree with our proposal to move to more ambitious thresholds on the best practice tariffs for day case procedures to manage female incontinence?
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
14%
86%
0%
100%
0%
100%
24%
76%
27%
73%
27%
73%
11%
89%
No%
Yes%
Total
CCGs
CSUs
NHS Trusts
NHS FTs
Independe...
Other*

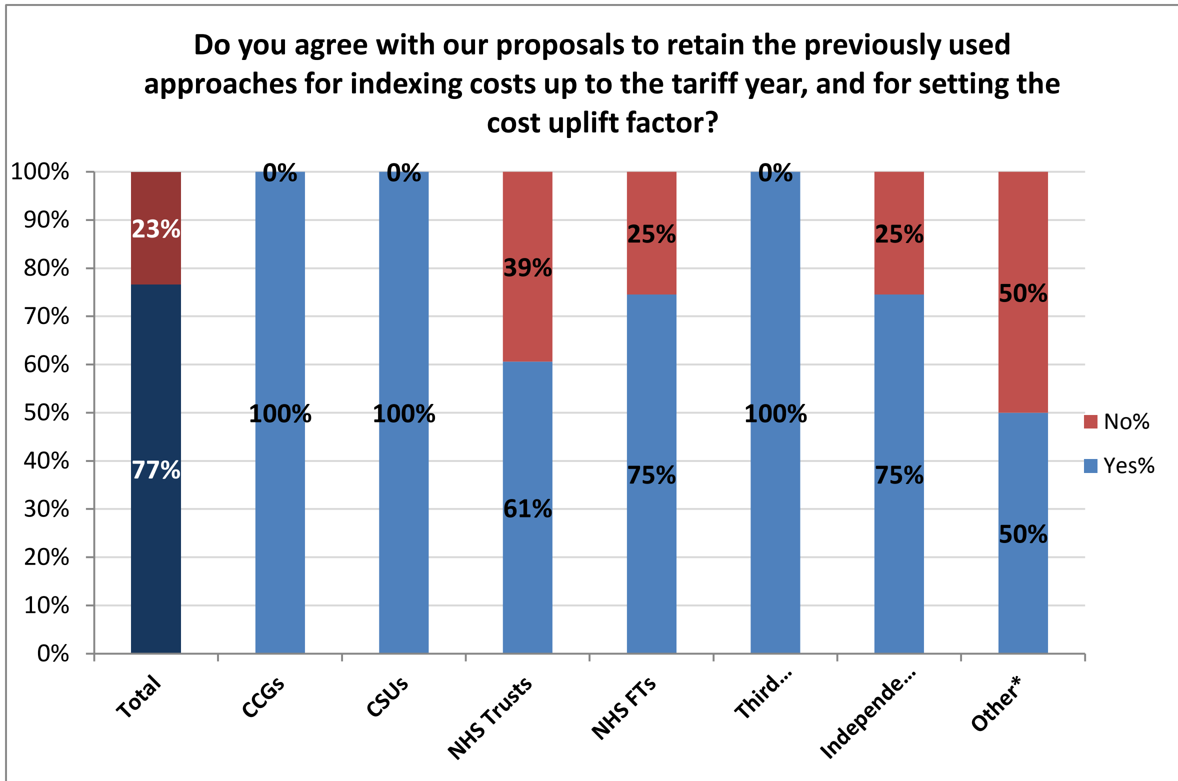

Do you agree with our proposal to move to more ambitious thresholds on the best practice tariffs for tympanoplasty day case procedures?
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
14%
86%
0%
100%
100%
26%
74%
32%
68%
32%
68%
100%
No%
Yes%
Total
CCGs
CSUs
NHS Trusts
NHS FTs
Independe...
Other*


Do you agree with our proposal to move to more ambitious thresholds on the best practice tariffs for diagnostic hysteroscopy outpatient procedures?
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
13%
88%
0%
100%
0%
100%
23%
77%
24%
76%
24%
76%
0%
100%
No%
Yes%
Total
CCGs
CSUs
NHS Trusts
NHS FTs
Independe...
Other*


Count of Do you agree with our proposal to add 6 factors to the maternity pathway currency, to improve allocations?
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
21%
79%
21%
79%
0%
100%
24%
76%
29%
71%
29%
71%
0%
100%
No%
Yes%
Total
CCGs
CSUs
NHS Trusts
NHS FTs
Independe...
Other*


Do you agree with our proposed additions to the high cost drugs list?
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
15%
85%
16%
84%
29%
71%
11%
89%
9%
91%
9%
91%
31%
69%
No%
Yes%
Total
CCGs
CSUs
NHS Trusts
NHS FTs
Independe...
Other*


Do you agree with our proposed changes to the short stay emergency (SSEM) bands and eligibility?
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
16%
84%
6%
94%
0%
100%
35%
65%
19%
81%
19%
81%
14%
86%
No%
Yes%
Total
CCGs
CSUs
NHS Trusts
NHS FTs
Independe...
Other*


Do you agree with our proposals to retain the previously used approaches for indexing costs up to the tariff year, and for setting the cost uplift factor?
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
23%
77%
0%
100%
0%
100%
39%
61%
25%
75%
0%
100%
25%
75%
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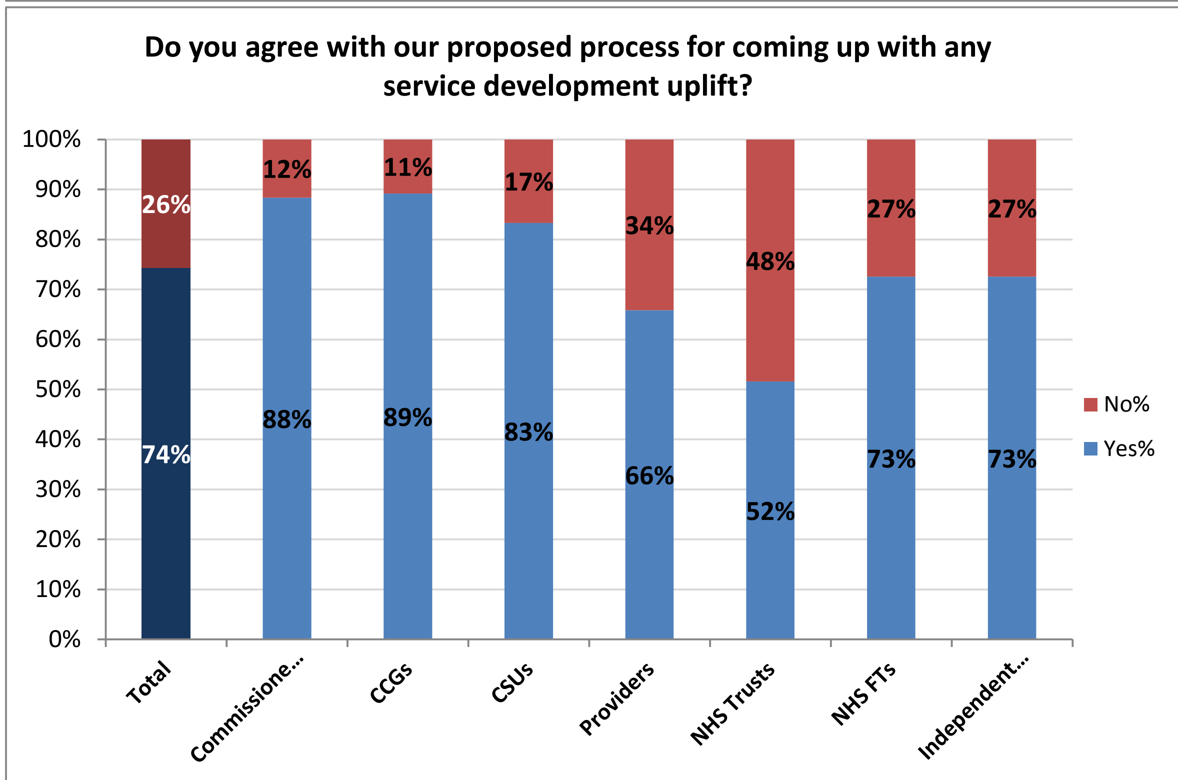
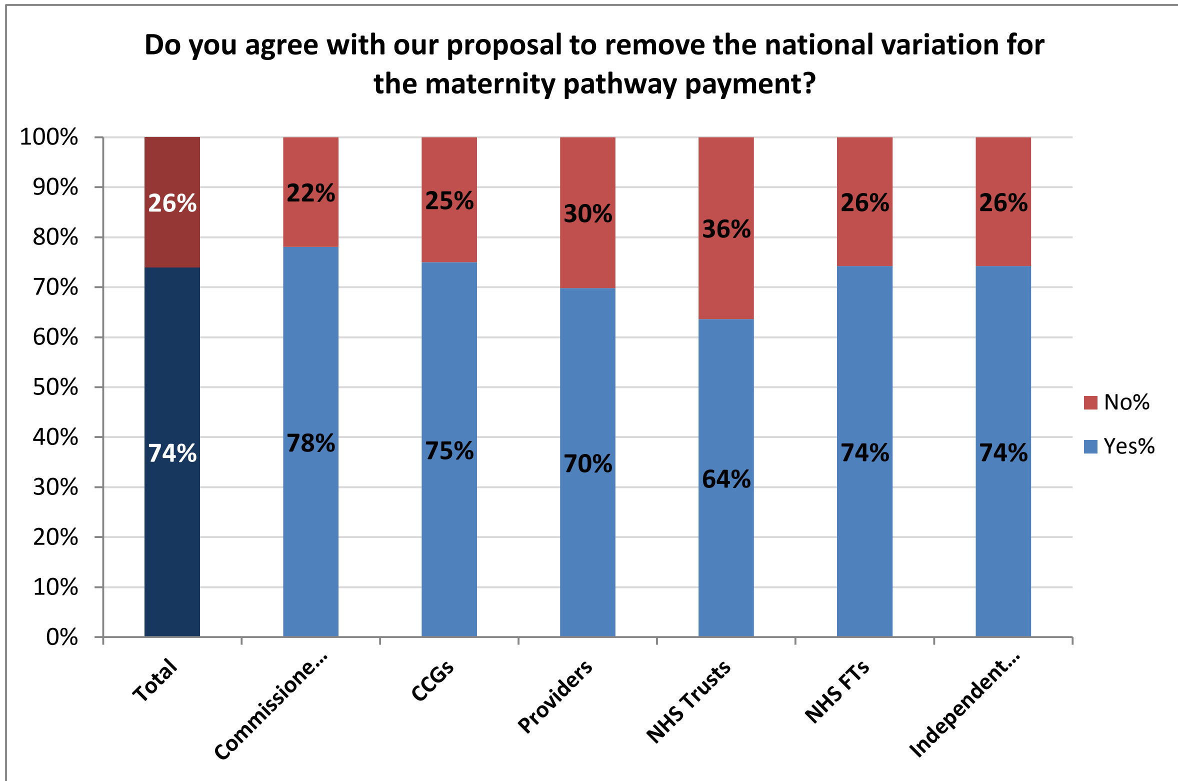
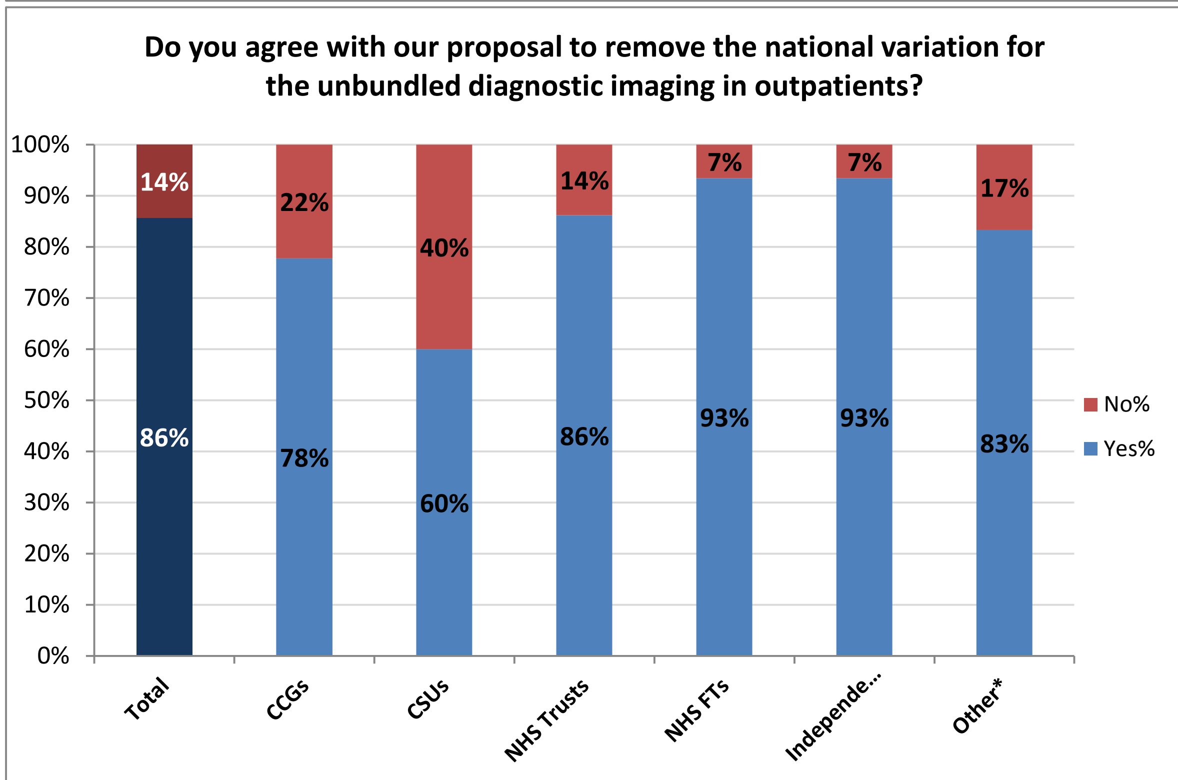
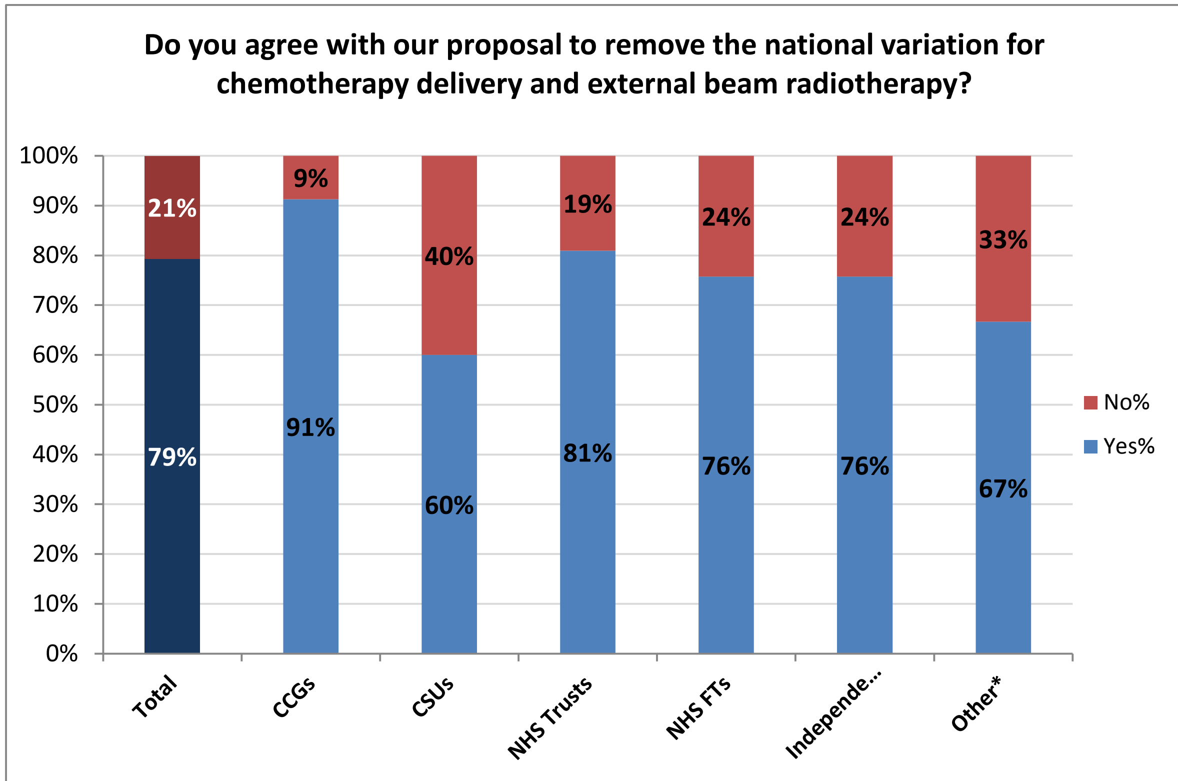
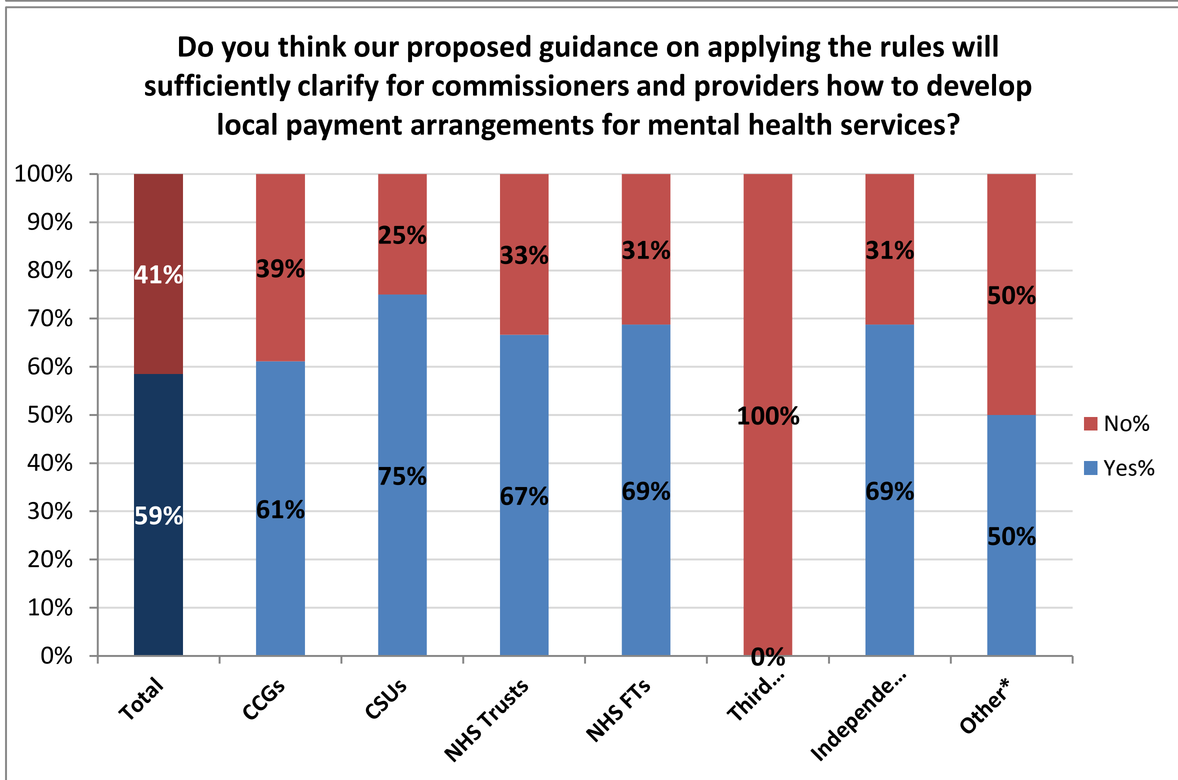
Total
CCGs
CSUs
NHS Trusts
NHS FTs
Third...
Independe...
Other*

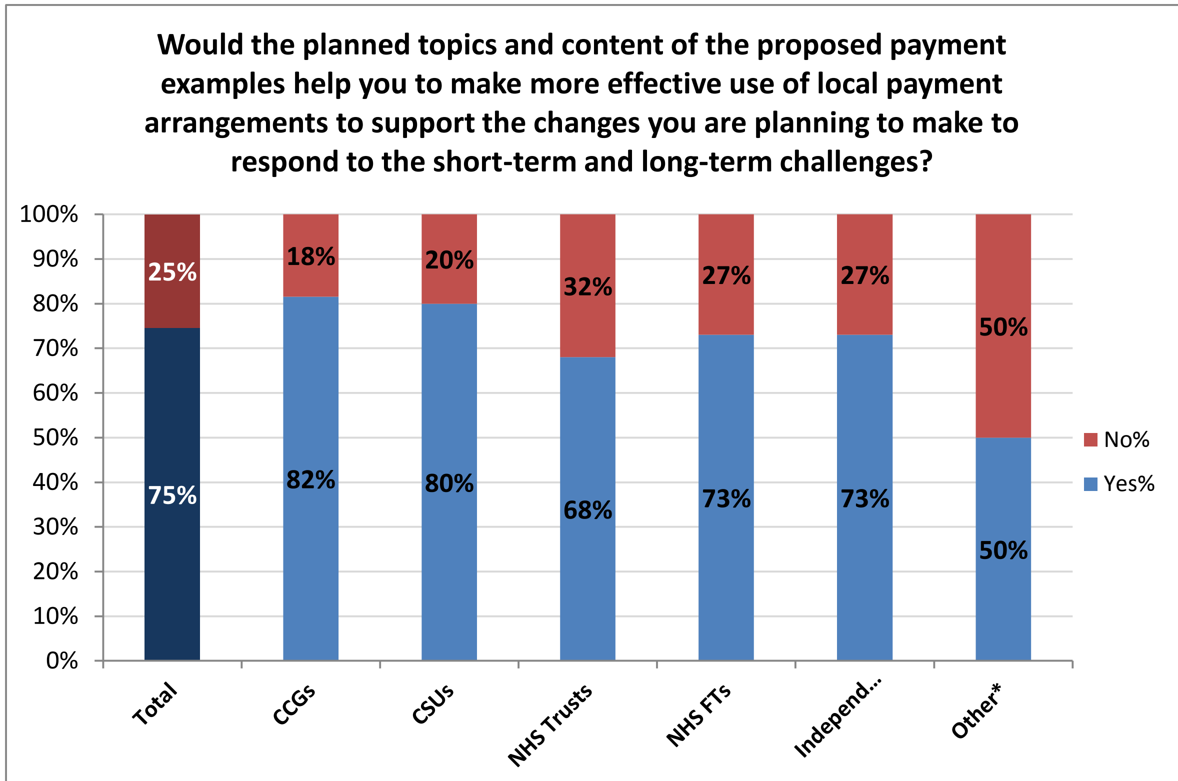

Do you agree with our proposed process for coming up with any service development uplift?
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
26%
74%
12%
88%
11%
89%
17%
83%
34%
66%
48%
52%
27%
73%
27%
73%
No%
Yes%
Total
Commissione...
CCGs
CSUs
Providers
NHS Trusts
NHS FTs
Independent...

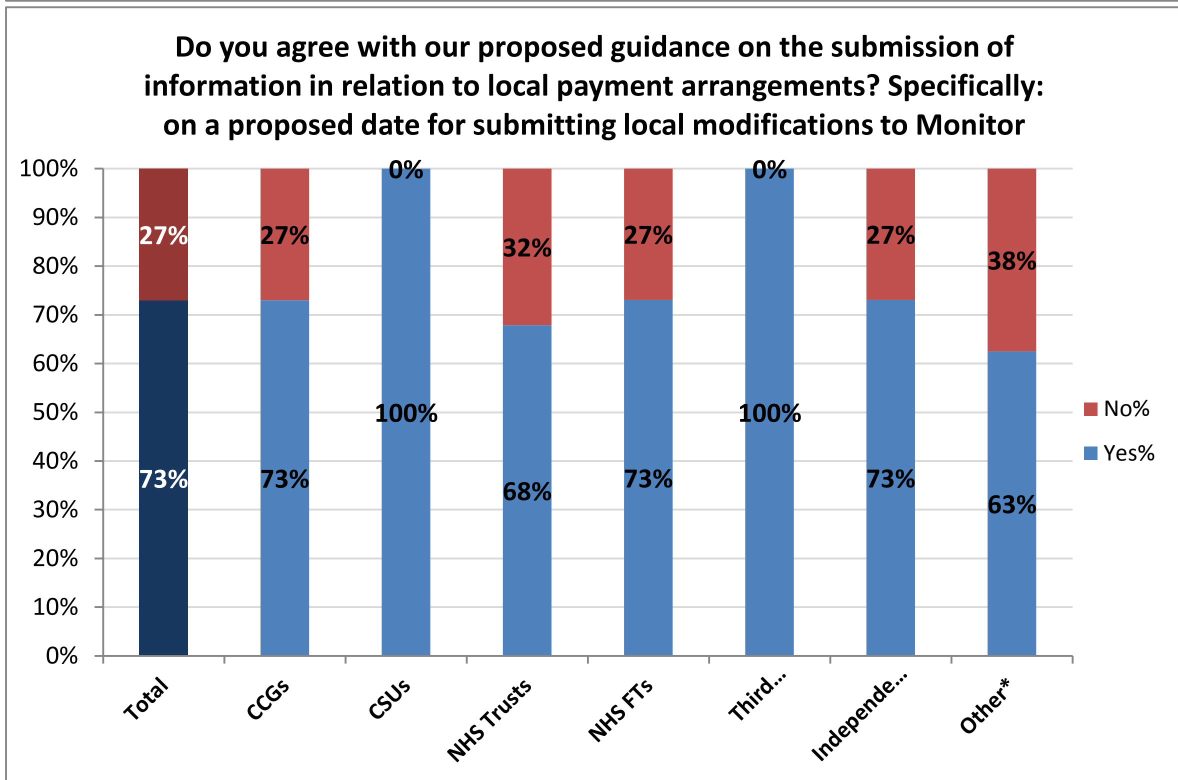

Do you agree with our proposal to remove the national variation for the maternity pathway payment?
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
26%
22%
25%
30%
36%
26%
26%
74%
78%
75%
70%
64%
74%
74%
No%
Yes%
Total
Commissione...
CCGs
Providers
NHS Trusts
NHS FTs
Independent...

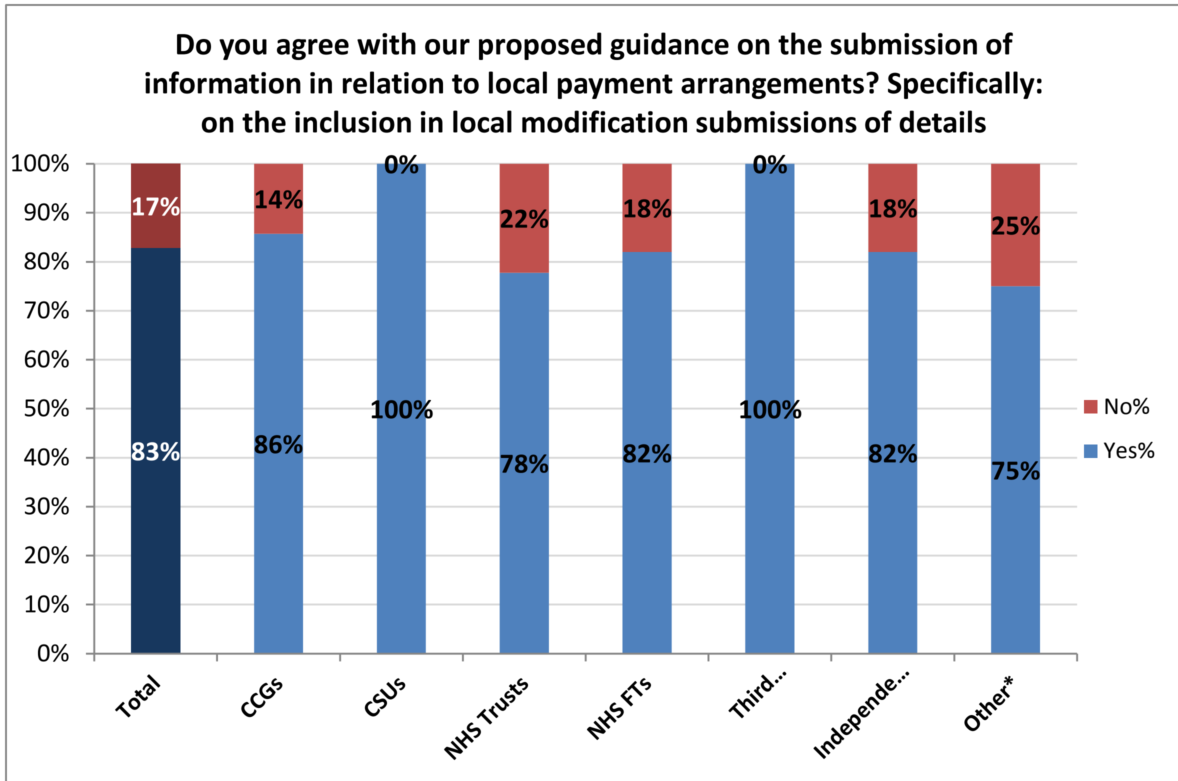

Do you agree with our proposal to remove the national variation for the unbundled diagnostic imaging in outpatients?
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
14%
22%
40%
14%
7%
7%
17%
86%
78%
60%
86%
93%
93%
83%
No%
Yes%
Total
CCGs
CSUs
NHS Trusts
NHS FTs
Independe...
Other*


Do you agree with our proposal to remove the national variation for chemotherapy delivery and external beam radiotherapy?
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
21%
79%
9%
91%
40%
60%
19%
81%
24%
76%
24%
76%
33%
67%
No%
Yes%
Total
CCGs
CSUs
NHS Trusts
NHS FTs
Independe...
Other*


Do you think our proposed guidance on applying the rules will sufficiently clarify for commissioners and providers how to develop local payment arrangements for mental health services?
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
41%
59%
39%
61%
25%
75%
33%
67%
31%
69%
100%
0%
31%
69%
50%
50%
No%
Yes%
Total
CCGs
CSUs
NHS Trusts
NHS FTs
Third...
Independe...
Other*


Would the planned topics and content of the proposed payment examples help you to make more effective use of local payment arrangements to support the changes you are planning to make to respond to the short-term and long-term challenges?
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
25%
75%
18%
82%
20%
80%
32%
68%
27%
73%
27%
73%
50%
50%
No%
Yes%
Total
CCGs
CSUs
NHS Trusts
NHS FTs
Independ...
Other*


Do you agree with our proposed guidance on the submission of information in relation to local payment arrangements? Specifically: on a proposed date for submitting local modifications to Monitor
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
27%
73%
27%
73%
0%
100%
32%
68%
27%
73%
0%
100%
27%
73%
38%
63%
No%
Yes%
Total
CCGs
CSUs
NHS Trusts
NHS FTs
Third...
Independe...
Other*


Do you agree with our proposed guidance on the submission of information in relation to local payment arrangements? Specifically: on the inclusion in local modification submissions of details
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
17%
83%
14%
86%
0%
100%
22%
78%
18%
82%
0%
100%
18%
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75%
No%
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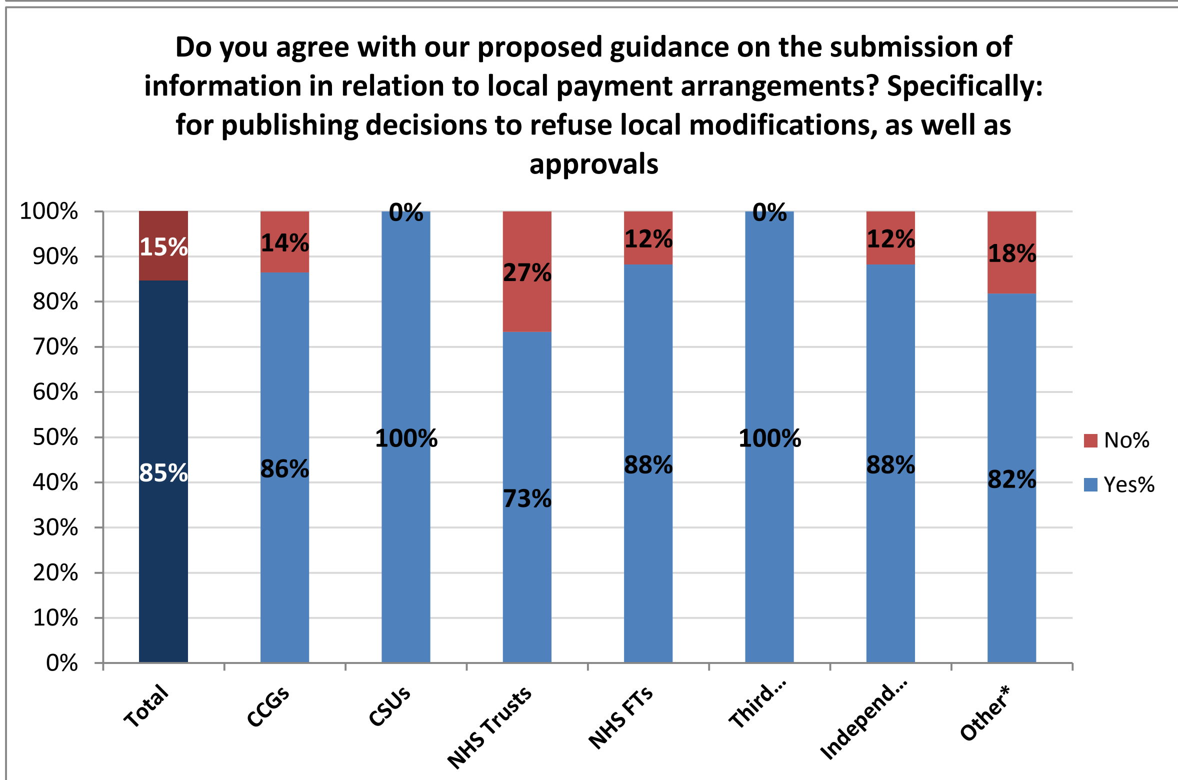
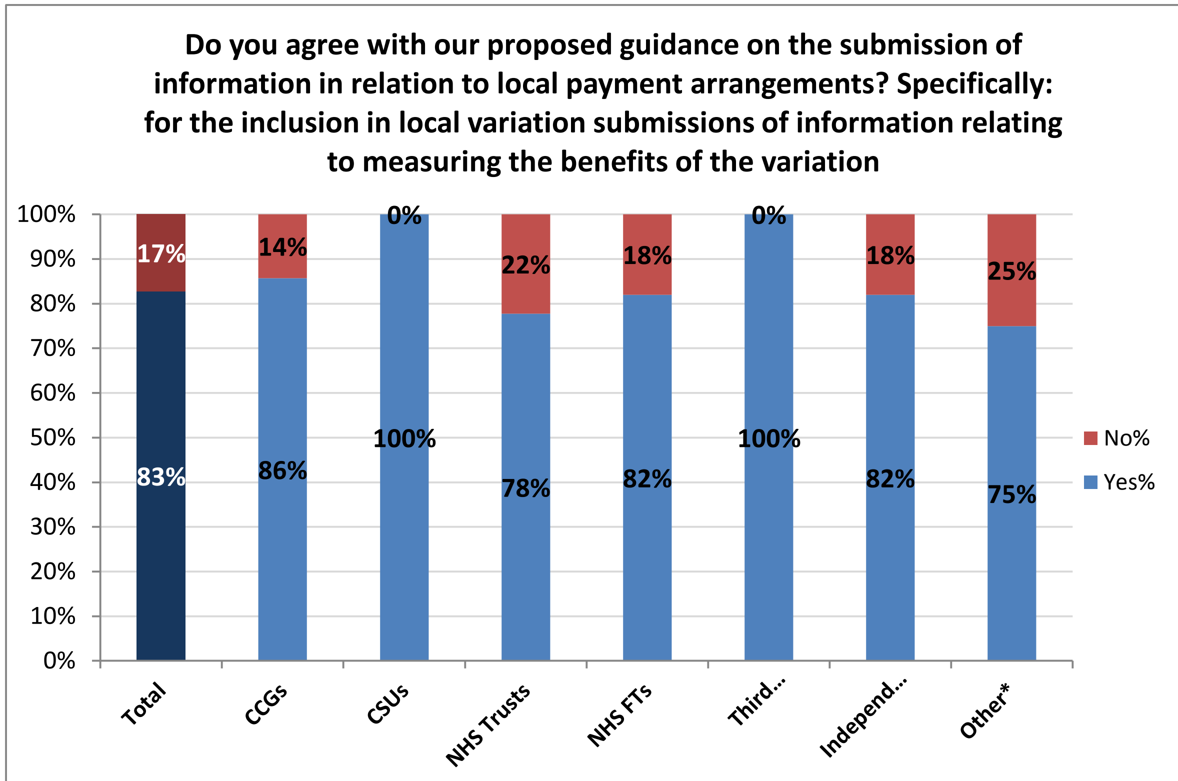
Total
CCGs
CSUs
NHS Trusts
NHS FTs
Third...
Independe...
Other*


Do you agree with our proposed guidance on the submission of information in relation to local payment arrangements? Specifically: for publishing decisions to refuse local modifications, as well as approvals
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
15%
85%
14%
86%
0%
100%
27%
73%
12%
88%
0%
100%
12%
88%
18%
82%
No%
Yes%
Total
CCGs
CSUs
NHS Trusts
NHS FTs
Third...
Independ...
Other*


Do you agree with our proposed guidance on the submission of information in relation to local payment arrangements? Specifically: for the inclusion in local variation submissions of information relating to measuring the benefits of the variation
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
17%
83%
14%
86%
0%
100%
22%
78%
18%
82%
0%
100%
18%
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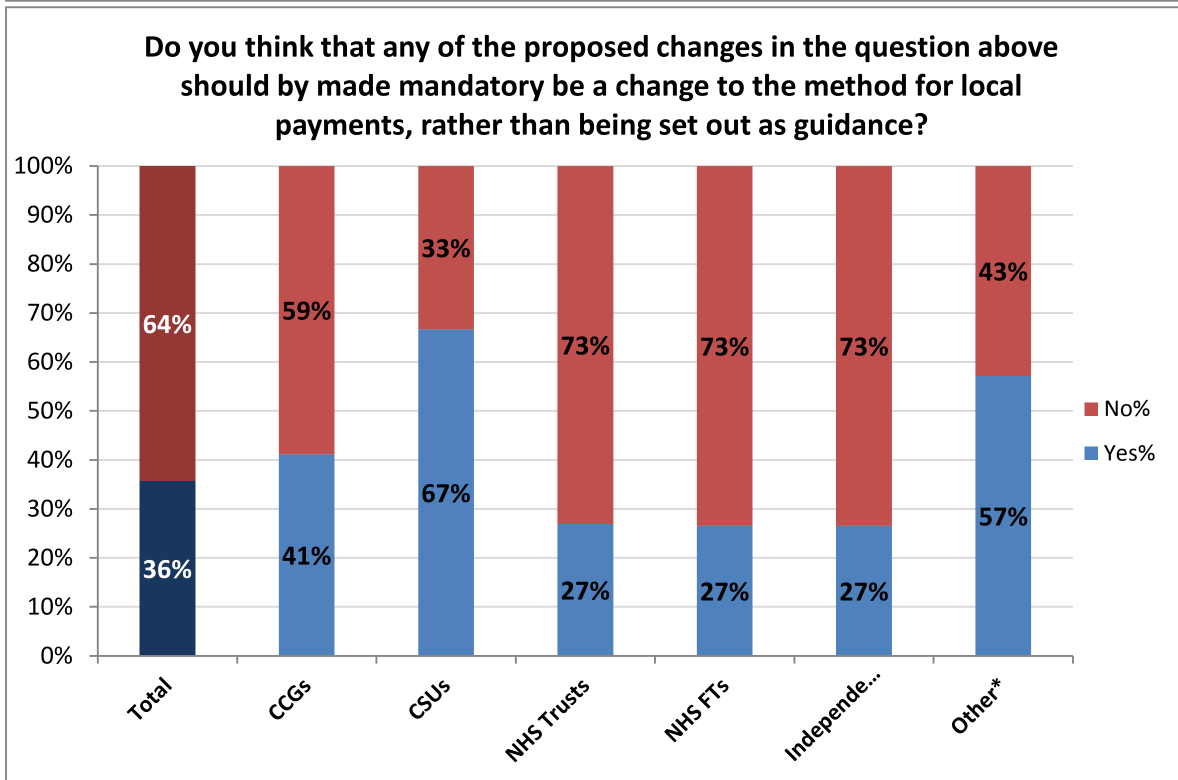
75%
No%
Yes%
Total
CCGs
CSUs
NHS Trusts
NHS FTs
Third...
Independ...
Other*


Do you think that any of the proposed changes in the question above should by made mandatory be a change to the method for local payments, rather than being set out as guidance?
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
64%
36%
59%
41%
33%
67%
73%
27%
73%
27%
73%
27%
43%
57%
No%
Yes%
Total
CCGs
CSUs
NHS Trusts
NHS FTs
Independe...
Other*

1 Annex B: Objecting to the method

The purpose of this annex is to provide guidance on the process by which clinical commissioning groups (CCGs) and 'relevant providers' (see page 10 of the 'Cover note' for a definition) can object to the method for determining national prices proposed for the '2015/16 National Tariff Payment System', as set out in this notice. In this annex, we:

- describe what constitutes the proposed method and therefore what might be objected to
- explain which CCGs and providers can object to the proposed method
- detail how CCGs and relevant providers can submit their objections to the proposed method
- explain the process for a reference to the Competition and Markets Authority (CMA)
- set out the proposed timetable for publication of the '2015/16 National Tariff Payment System'.

1.1 Scope: what constitutes the 'method'

The proposals for the '2015/16 National Tariff Payment System' set out in this consultation notice are subject to a statutory consultation process. Stakeholders can comment and give their views on any of the proposals.

Section 120 of the Health and Social Care Act 2012 (the 2012 Act) sets out a process for commissioners and relevant providers to challenge the method or methods proposed for determining the national prices to be specified in the national tariff.[16] This process applies only to the proposed method(s) for determining national prices, and not to other proposals in the consultation notice. The 'method' is the data, methodology and calculations used to arrive at the proposed set of national prices, but not the prices themselves.

[16] The 2012 Act, sections 118(3)(b) and 120(1).

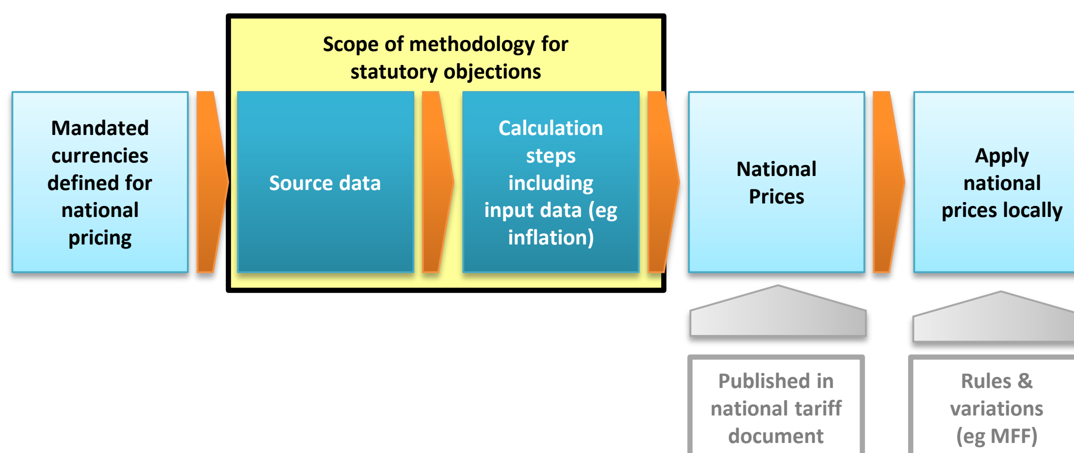
Further, the method is separate from and does not include:

- the proposed national variations
- the rules, methods and principles that we propose to govern local variations, local modifications or local price setting.

National variations, which include the Market Forces Factor (MFF), specialist top-ups and the marginal rate for emergency admissions, apply to national prices but are not part of the method for determining those prices. CCGs and providers may comment on the proposals for the variations in their response to the consultation, but any objections to the variations in those responses do not count for the purpose of the statutory objection process described below.

Figure B1 illustrates the scope of the proposed method for determining national prices in the '2015/16 National Tariff Payment System'.

Figure B.1: Scope of the proposed method



Our proposed method for calculating 2015/16 prices for services that currently have a national price under the '2014/15 National Tariff Payment System' has several elements that are described in detail in Section 5 of the consultation notice. In addition to this main method, the section also specifies the proposed methods for determining the prices of services to be specified for the first time as services subject to a national price. For ease of reference, in the rest of this annex, references to 'the method' include all the proposed methods set out in Section 5 of the consultation notice.

Objecting to national variations

The 2012 Act does not permit statutory objections to national variations such as the marginal rate rule and the Market Forces Factor. In this box we explain why.

Section 120 of the 2012 Act sets out the statutory objections process. In particular, it states that if Monitor receives more than a prescribed percentage of objections from either CCGs or relevant providers 'to a method it proposes under section 118(3)(b)', Monitor may not publish the final national tariff unless it has made a reference to the CMA. In those circumstances Monitor would also have the option of amending the proposals and re-consulting under section 118 of the 2012 Act.

It follows that the statutory objection process is limited to proposals under section 118(3)(b). Section 118(3)(b) states that the notice published by Monitor must include 'the method or methods it proposes to use for determining the national prices of the specified services'.

While section 118 of the 2012 Act provides that Monitor must (or may) specify a number of other matters in the notice, these are not subject to the objection process. These include national variations under section 118(5)(a) of the 2012 Act, which are applied to national prices but are not part of the method for determining those prices.

Of course, while the national variations cannot be objected to formally under the statutory objection process, we welcome feedback on all our proposals.

1.2 Who can object to the method?

The 2012 Act specifies that it is only objections to the method from CCGs and relevant providers that count for the purposes of the statutory objection process.[17] This means only these objections can determine whether Monitor can proceed to publish without further consultation or a reference to the CMA.

[17] 2012 Act, section 120(1).

There are two categories of relevant provider:

- Licence holders – for the consultation on the '2015/16 National Tariff Payment System', this includes all NHS foundation trusts and many independent sector providers of NHS services.
- Other relevant providers as specified in the NHS (Licensing and Pricing) Regulations 2013.[18] The effect of those regulations is that a person is a relevant provider if they provide an NHS service[19] for which there is a national price proposed in this consultation notice.[20] This refers to current providers of the service. The definition of relevant provider includes all NHS trusts currently providing services that would be subject to a proposed national price.

Other commissioners and providers can respond to the consultation and voice their objections to the proposals, but those objections will not be included in the statutory objection process. This includes objections from:

- prospective providers who intend to provide a service for which there is a national price next year, but who do not currently provide that service
- the NHS England teams responsible for commissioning specialised services – those teams are within the body of NHS England and are not CCGs.

[18] S.I. 2013/2214; see regulation 6. The Regulations are available at www.legislation.gov.uk/uksi/2013/2214/pdfs/uksi_20132214_en.pdf.

[19] Our proposals for services to be subject to a proposed national price are set out in Section 4 of Part 2 of the notice, which includes some new services.

[20] In addition, a person is a relevant provider for the purposes of the share of supply percentage only if they provide services which have a current national price in the 2014/15 national tariff, as well as a proposed price in this consultation notice.

1.3 The process for objecting to the method

The 2012 Act provides that Monitor may not publish the final national tariff (without a reference to the CMA) unless:

- the proportion of CCGs objecting to the method is less than the prescribed percentage
- the proportion of relevant providers objecting to the method is less than the prescribed percentage
- the proportion of relevant providers objecting to the method, weighted by their 'share of supply', is less than the prescribed percentage.

The percentages, and the method for calculating share of supply, have been prescribed in regulations.[21] The relevant prescribed percentage in each case is 51%.

This means that Monitor must either reconsult or make a reference to the CMA for its determination if either:

- the percentage of CCGs objecting to the method is greater than, or equal to, 51%
- the percentage of relevant providers objecting to the method is greater than, or equal to, 51%
- the percentage share of tariff income received by providers who objected to the proposal for the financial year 1 April 2013 to 31 March 2014 is greater than, or equal to, 51% of total tariff income for that year.

Figure B.2 illustrates the process for determining whether to publish the national tariff, reconsult, or make a referral to the CMA.

[21] See regulation 5 of the National Health Service (Licensing and Pricing) Regulations 2013 (SI 2013/2214), www.legislation.gov.uk/uksi/2013/2214/pdfs/uksi_20132214_en.pdf.

Figure B.2: Publish, reconsult and referral cycle

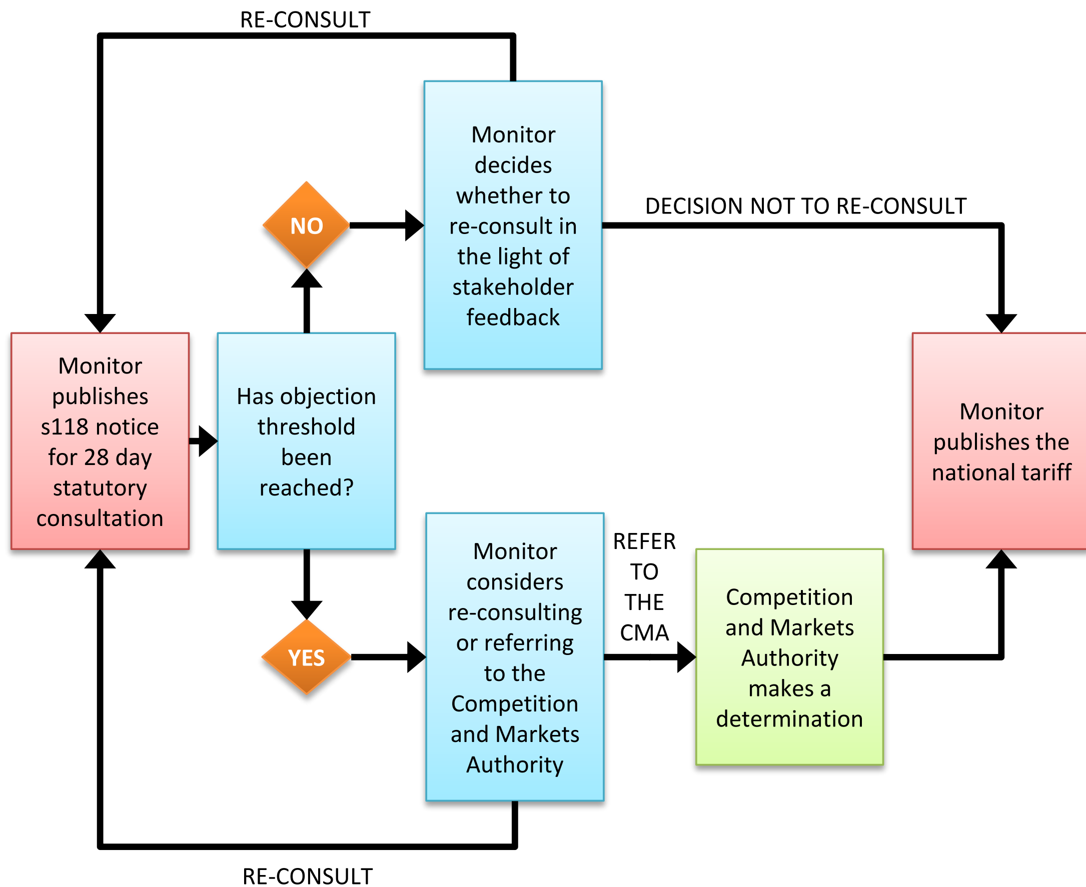


Figure B.2 further illustrates the possible outcomes after statutory consultation:

- If none of the objection thresholds has been reached, and Monitor decides, after consideration of stakeholder feedback, that there is no requirement to make a significant change to the proposed method for determining national prices, Monitor will publish the '2015/16 National Tariff Payment System'.

- If none of the objection thresholds has been reached, and Monitor decides, after consideration of stakeholder feedback, that there is a requirement to make a significant change to the proposed method for determining national prices which requires further consultation, Monitor will issue a revised consultation notice and reconsult for 28 days.
- If one or more of the objection thresholds has been reached, and Monitor decides to reconsult, Monitor will issue a revised consultation notice and reconsult for 28 days.
- If one or more of the objection thresholds has been reached, Monitor can make a reference to the CMA for their determination. Monitor would make changes to the method to address the issues raised in the determination and, subject to the CMA's power to veto proposed changes, publish the '2015/16 National Tariff Payment System'.

If Monitor issues a revised consultation notice for another 28-day period, this further consultation will be subject to the same rules – that is, CCGs and relevant providers could object to the proposed method, and all stakeholders can submit their views on the proposals. This process would continue until:

- the proportion of objections reduces to a level at which none of the objection thresholds is met
- the CMA upholds Monitor's method
- changes are made to the method, in accordance with the CMA's determination.

The '2015/16 National Tariff Payment System' cannot be published until one of these three outcomes is achieved.

In summary, if all three of the objection percentages listed above are less than 51%, Monitor will, subject to consideration of the other responses to the consultation, publish the '2015/16 National Tariff Payment System', using the method as stated in this notice. If any of the percentages is greater than or equal to 51%, Monitor may either adjust its methodology and reconsult or make a referral to the CMA for its determination.

Objections to the method should be made by the CCG or relevant provider, not by individual units or departments of those bodies. An objection should be an objection agreed by that legal entity, rather than be the sole view of an individual or team within it. It is the responsibility of individual CCGs and relevant providers to ensure proper internal processes for deciding to make an objection (for example, a process of obtaining agreement of members, governing bodies or the board).

CCGs and relevant providers should provide reasons for their objection to the method. A failure to do so does not invalidate the objection, but if the reasons are not raised at this stage, they may be subsequently disregarded by the CMA when it determines any reference.[22]

Should a CCG or relevant provider decide to object to the method proposed for the '2015/16 National Tariff Payment System', the organisation's objection can be registered in a web-based response form at: https://www.research.net/s/NT1516.

Further comments on the consultation notice can be emailed to: paymentsystem@monitor.gov.uk.

Irrespective of the number of separate objections from a CCG or relevant provider, for the purposes of calculating the objection percentages (as set out above), each legal entity will be counted only once.

Monitor will aim to confirm receipt of any objections it receives.

[22] See paragraph 5 of Schedule 12 to the 2012 Act.

1.4 The procedure for reference to the Competition and Markets Authority

The procedure Monitor would follow when referring the method to the CMA, should any one of the objection thresholds be reached, is set out in the 2012 Act.[23] In addition, in February 2014 rules and guidance were published by the Competition Commission, which provide further details of the procedure to be followed.[24] The following paragraphs provide a brief summary of the procedure.

Section 121(4) of the 2012 Act sets out the grounds on which the CMA may determine that the proposed method is not suitable. Monitor's reference must include its reasons for proposing the method and its representations as to why those grounds do not apply. A copy of the reference will be sent to the objectors, who will have an opportunity to make representations to the CMA.[25] The representations must be submitted within 10 working days of receiving the reference. Those representations should include:

- the reasons that the objector considers Monitor's decision on the method was wrong, on the basis of one of the grounds set out in section 121(4) of the 2012 Act
- any changes to the method the objector considers appropriate
- any supporting documents.

Third parties may also have an opportunity to submit representations within 10 days of the publication of the reference on the CMA website.

Monitor will have an opportunity to make a written reply to any representations.

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23 See sections 120 to 123 of the 2012 Act and schedule 12 to the 2012 Act.

24 See the National Tariff Methodology Reference Rules under the Health and Social Care Act 2012 (CC21)and the the National Tariff Methodology Reference Rules under the Health and Social Care Act 2012 (CC22). Although published by the Commission, they have been adopted by the CMA and are available at www.gov.uk/government/collections/cma-regulatory-appeals-and-references-guidance

25 See schedule 12 to the 2012 Act.

All participants in the process will be encouraged to provide the CMA with a coherent and comprehensible explanation of any technical issues.

A group appointed by the chair of the CMA will determine the reference, based on Monitor's submissions, the objectors' representations and any other evidence submitted to or gathered by the CMA (for example, submissions made by interested third parties).

The CMA must determine the reference within 30 working days.[26] The CMA expects to set an administrative timetable designed to enable the CMA and the parties to conduct a satisfactory reference process within the statutory timescale. The CMA is entitled to disregard any matter raised by an objector in their representations that was not raised at the time of their original response to Monitor.[27]

The CMA must order the payment of its costs at the end of the process. If the CMA decides the method is suitable, objectors will be required to meet the costs incurred by the CMA, and they may also be ordered to pay some of Monitor's costs. If the CMA decide the method is not suitable, Monitor will be required to pay the CMA's costs, and may be ordered to pay some of the objectors' costs.

1.5 The timetable

Below, we set out our expectations for the timetable for publication of the '2015/16 National Tariff Payment System', if:

- none of the objection thresholds is met
- any of the objection thresholds is met, and consequently Monitor needs to either reconsult or make a reference to the CMA.

[26] This may be extended by 20 working days.

[27] Similarly, the CMA is entitled to disregard any matter raised by Monitor in its replies to objectors' representations, if not raised in Monitor's reference document.

1.5.1 Proposed timetable if none of the objection thresholds is met

The statutory consultation period of 28 days ends on 24 December 2014, after which Monitor will calculate the objection and share of supply percentages. If none of the objection thresholds is reached, and subject to consideration of other consultation responses, Monitor would aim to publish the '2015/16 National Tariff Payment System' document in early 2015.

1.5.2 Proposed timetable if any of the objection thresholds are met

If the proportion of objections is 51% or greater on any of the three objections thresholds, Monitor will either:

- revise the method in light of the objections and reconsult
- make a reference to the CMA.

In the latter case, for some of the steps that would need to be taken the 2012 Act specifies the number of days for completion. For other steps, the 2012 Act does not specify a time period. This means it is difficult, at this stage, for us to be prescriptive or definitive about the likely timetable.

Notwithstanding the above, for guidance, the table below sets out the main steps (and associated timeframes, where known) in the event that Monitor refers the method to the CMA.

Table B.1: Main steps under a referral to the Competition and Markets Authority

Step	Number of days prescribed by the 2012 Act	Date(s)
Monitor issues section 118 Notice	N/A	26 November 2014
Statutory consultation period	28 (consecutive, working and non-working) days	Start: 27 November 2014 End: 24 December 2014
Monitor determines whether objections are below/above objection thresholds set out in the regulations	Not specified in the Act	Unknown at this stage
Monitor sends a reference to the CMA	N/A	Unknown at this stage
Monitor informs objectors of the reference to the CMA	N/A	Same time as the notice is submitted to the CMA
Objectors submit their representations to the CMA and Monitor	10 (working) days	Unknown at this stage
Monitor responds to objectors representations and sends a copy of the response to objectors and the CMA	10 (working) days	Unknown at this stage
The CMA determines reference (including any oral hearing and written submissions)	30 (working) days	Unknown at this stage
The CMA extends the period for determining the reference	Up to 20 additional (working) days These are in addition to the 30-day period, which the CMA can add, if required.	Unknown at this stage

Based on the above, if there is a CMA reference, publication of the '2015/16 National Tariff Payment System' is likely to be delayed until, at the earliest, spring 2015.

In the event that the '2015/16 National Tariff Payment System' cannot be published before 1 April 2015, the prices, methods and rules in the '2014/15 National Tariff Payment System' would continue in force until the new national tariff came into effect.

Foreword

The key challenge for the NHS is to improve the things that matter to patients whilst keeping within a fixed budget. This will help ensure the sustainability of a high quality, tax-funded healthcare system.

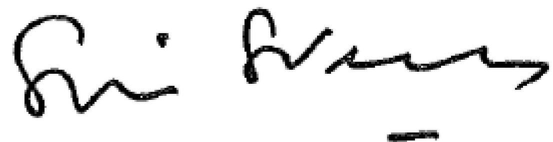
It has become increasingly clear to us that we need to re-design the healthcare system to make real progress. The payment system is one of a range of levers which needs to support this process. The '2015/16 National Tariff Payment System' aims to support commissioners and providers in delivering new models of care through increased flexibility and transparency.

We need to enable the service to deliver good care to patients in very difficult circumstances (the budget has been flat in real terms for four years, which is unprecedented in the sector in the recent past). In doing so, we need to improve efficiency standards and meet key performance metrics, whilst keeping activity growth under control. The payment system needs to support this effort by helping to set the right incentives. This can be achieved by encouraging providers to seek opportunities for cost savings and for commissioners and providers to share financial risk around unplanned activity growth, where appropriate to do so.

2015/16 in particular will be a very challenging year and will require commissioners and providers to work together in a real spirit of co-operation in the best interests of patients. NHS England and Monitor will also continue to work closely together to strengthen the building blocks underpinning the tariff and set out a joint direction for the payment system change. We have a joint programme of work to support payment reform that we will soon publish, building on the vision described in the 'Five Year Forward View'.

The '2015/16 National Tariff Payment System' is the second national tariff that NHS England and Monitor have produced together. In this document we set out what we consider to be the appropriate payment system design for 2015/16, based on where we are starting from and what further reforms we are working towards introducing in coming years. We would like to thank those people and organisations that have helped us develop these proposals, both through the formal consultation process and through a great detail of detailed work on specific proposals.

Overall, we are keen to continue to work together to find ways to continue to improve care for patients in what are clearly difficult times.



Dr David Bennett
Chief Executive, Monitor

Simon Stevens
Chief Executive, NHS England

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Executive summary

NHS England and Monitor are jointly responsible for the NHS payment system under the provisions of the Health and Social Care Act 2012 ('the 2012 Act'). The '2015/16 National Tariff Payment System' is the second national tariff that NHS England and Monitor have produced together since the 2012 Act came into force. Our long-term aim is to develop a payment system that supports the efficient delivery of quality care for patients in a sustainable way.

The sector faces a series of major challenges that commissioners and providers must work together to address over the coming year, including:

- increasing demand (driven by demographic pressures, increasing public expectations and the availability of new treatment options); in particular, expenditure on specialist services was significantly over budget for 2013/14 and is currently growing at an unsustainable rate
- an NHS settlement that contains only a small real terms increase, following several years of low growth in funding
- upward cost pressures, particularly relating to staffing.

A major part of the response to these challenges is to move towards new patterns of care as indicated in the 'NHS Five Year Forward View'.[29] However, this change in the pattern of care will take time to design and implement. It is important that the NHS continues to make operational improvements in parallel, so that patients continue to receive good care while major service change is taking place.

The '2015/16 National Tariff Payment System' sets a demanding but, we believe, achievable challenge for providers to deliver services more efficiently, and for both commissioners and providers to ensure appropriate activity growth while getting on with the necessary pathway redesigns. Specifically, it:

- **Challenges providers to deliver current models of care as efficiently as possible.** We are setting a single efficiency factor of 3.8% for 2015/16. While we accept that this is a challenging target, our analysis – based on data from acute providers – indicates it is appropriate. This reflects our expectation that 2015/16 will require a further exceptional effort from all parts of the sector, to respond to the financial challenge. For this year, we will keep the cost base constant in aggregate, while we investigate in more detail providers' actual costs.

[2929] The 'NHS Five Year Forward View' was developed by the partner organisations that deliver and oversee health and care services including NHS England, Public Health England, Monitor, Health Education England, the Care Quality Commission and the NHS Trust Development Authority.

- **Focuses providers and commissioners on ensuring that specialised services expenditure secures value for patients.** We have reviewed the comparative rates of growth and drivers of income for acute services with and without national prices. The relatively rapid rate of activity and cost growth in acute services without national prices, particularly specialised services, has led us to introduce a new national variation and local price-setting rule to the effect that the risks associated with expenditure above an agreed base level are shared equally between providers and commissioners. This rule has been designed to encourage commissioners and providers to work together to ensure that activity growth represents good value.
- **Encourages providers and commissioners to work together to manage emergency admissions.** We have listened to feedback and are revising the marginal rate rule for emergency admissions so that the financial risks above a baseline budget are shared equally between providers and commissioners. The intention of this change is to further incentivise the system to work together to ensure that activity growth is appropriate and achieve good value for patients. This will also help to address some of the financial challenges for smaller hospitals where emergency admissions are a significant share of their activity.
- **Rewards providers appropriately for meeting stretching quality targets.** We are introducing a best practice tariff (BPT) for heart failure, and moving to more ambitious thresholds for four existing BPTs. These thresholds are considered achievable by our clinical advisers. The changes are designed to incentivise providers to deliver better quality care and value for patients.

Further, NHS England recently announced that it will invest an additional £80 million in 2015/16 to enable the introduction of access standards for mental health services. NHS England estimates that applying £40 million to early intervention in psychosis is equivalent to an uplift of around 0.35% in the funding of all mental health services in 2015/16. This uplift will contribute to ensuring parity of esteem between physical and mental health services.

In addition, we want to support commissioners and providers to develop new models of care at a faster pace. 2014/15 saw the introduction of greater local flexibility through the mechanism of local variations, which enabled commissioners and providers to explore alternative ways to organise and pay for care where this is in patients' interests. This year we are publishing some examples of how commissioners and providers can use local payment arrangements to develop innovative service models in their local health economies. Some of these examples cover mental health services and, together with refreshed guidance, aim to accelerate the development of alternatives to unaccountable block contracts. The examples provide a practical focus we hope will encourage appropriate

implementation of local variations. Implementation support will also be provided and the impact of new approaches will be evaluated on an ongoing basis.

Future changes

[This section will be updated with the publication of the '2015/16 National Tariff Payment System'.]

Over and above the policies in the '2015/16 National Tariff Payment System', NHS England and Monitor have a joint programme of work to support payment reform that will build on the vision described in the 'Five Year Forward View'.[30]

In addition, we will continue to focus on improving data quality to support the payment system, in particular the collection of accurate and timely patient-level cost, activity and quality data for all care settings. Monitor has set out a vision for the costing direction of travel,[31] including a transition to patient-level costing. The development of such information, and before that a more detailed analysis of reference costs, will allow us to deliver on a key longer term objective of using accurately measured costs to set prices.

Reference guide to key changes

The table below summarises the key changes from 2014/15, as set out in the '2015/16 National Tariff Payment System'.

Section	Summary of main changes from 2014/15
Scope of the '2015/16 National Tariff Payment System'	We are providing clarification on the interaction between the national tariff and personal health budgets, as well as the implications for the joint/co-commissioning of primary care by clinical commissioning groups.
Currencies with national prices	We are introducing a new best practice tariff (BPT) for non-elective admissions for heart failure. We are also introducing more ambitious thresholds for four existing BPTs: • day-case procedures (selected) • outpatient procedures (selected)

[30] *[We intend to publish a direction of travel for the payment system soon after publication of the consultation notice.]*
[31] *[Monitor intends to publish a vision for costing, including a transition to patient-level costing, soon after publication of the consultation notice.]*

	• endoscopy procedures • primary hip and knee replacement outcomes. We have also: • refined the factors used to determine the groupings for antenatal care within the maternity pathway to better reflect complexity • updated the lists of high cost drugs and devices that are reimbursed outside national prices.
Method for determining national prices	We have modelled prices based on reference costs, using a refreshed modelling approach. An efficiency factor of 3.8% will be adopted. To the extent that there are any new requirements in the NHS Mandate, service development costs will be accounted for. We are applying a new process to clean data inputs into the price-setting model.
National variations to national prices	We are removing the transitional national variations that were in place for: • maternity pathway payments • unbundled diagnostic imaging in outpatients • chemotherapy delivery and external beam radiotherapy. In addition, we are revising the marginal rate rule so that the financial risks of emergency admissions above an agreed baseline is equally shared between providers and commissioners.
Locally determined prices and rules	We are publishing a number of supporting documents to help demonstrate how some innovative service delivery models can be implemented by commissioners and providers.
Acute prescribed specialised services [New Section]	We are introducing a new national variation and a new rule for specialised services to the effect that the risks associated with expenditure above an agreed base level are equally shared.
Payment rules	No policy change from 2014/15.

1 Introduction

The '2015/16 National Tariff Payment System' is the second national tariff produced jointly by NHS England and Monitor[32] for the NHS under the Health and Social Care Act 2012 ('the 2012 Act'). The 2012 Act gives NHS England and Monitor responsibility for designing and implementing the payment system for NHS healthcare services for the financial year 2014/15 onwards. This includes setting national prices for certain healthcare services as well as setting the rules for local pricing negotiations between providers of healthcare services and commissioners. The Department of Health (DH) had this role in previous years.

The 2012 Act further provides a statutory regulatory structure for the national tariff. NHS England and Monitor have joint responsibility for the payment system, but Monitor alone has responsibility for:

- publishing a consultation notice setting out proposals for the national tariff as agreed by NHS England and Monitor[33]
- publishing the national tariff.[34]

This document is the latter of the two. Monitor has published this consultation notice on **26 November 2014** with a view to publishing the national tariff in early 2015.

In this introductory section, we:

- describe the context of this document, including the engagement process that has preceded it
- provide an overview of the contents of this document in the context of the 2012 Act
- state the period for which the '2015/16 National Tariff Payment System' has effect
- summarise the structure of this document
- summarise the supporting documents.

1.1 Consultation on the national tariff

[We will describe the outcome of this consultation when we publish the final '2015/16 National Tariff Payment System'.]

[32] Throughout the document the terms 'we' and 'our' are used to refer to both NHS England and Monitor. Where a specific role or responsibility falls to either NHS England or Monitor this is clearly stated. This applies mostly to enforcement, applications and disclosure requirements, where Monitor is the responsible body.
[33] 2012 Act, sections 118(1) and (2)
[34] 2012 Act, section 116(1)

1.2 Overview of this document

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

The pricing provisions of the 2012 Act provide for a comprehensive payment system including not only a set of specified currencies and associated prices, but also a set of principles, rules and methods. For this reason, and adopting the same approach as last year, we have given the national tariff for 2015/16 the title: '2015/16 National Tariff Payment System'.

Consistent with the 2012 Act, the '2015/16 National Tariff Payment System' specifies*:*

- a set of healthcare services provided for the purposes of the NHS which are to have national prices (which we refer to as 'currencies')[35]
- the method used to determine the national prices of the specified services[36]
- the national price of each specified service (whether specified as an individual service, as a bundle of services, or within a group of services)[37]
- variations to the national price for a service by reference to factors relevant to the provision of that service (we refer to these as national variations)[38]
- the methods for approving an agreement between a provider and a commissioner to modify a nationally determined price, and the method for determining a provider's application to modify a nationally determined price (we refer to these modifications as local modifications).[39]

[35] 2012 Act, section 116(1)(a)
[36] 2012 Act, section 116(1)(b)
[37] 2012 Act, section 116(1)(c)
[38] 2012 Act, section 116(4)(a)
[39] 2012 Act, section 116(1)(d)

In addition, the '2015/16 National Tariff Payment System' provides for:

- The rules under which providers and commissioners may agree to vary the specification or the national price of services.[40] A variation agreed under these rules is called a local variation.
- The rules for determining the price payable for the provision of services that do not have a specified national price.[41] A price set under these rules is called a local price.
- The rules for determining which currency applies in cases where a service is specified in more than one way (that is, there is more than one currency for the same service).[42]
- The rules relating to making of payments to a provider for the provision of healthcare services.[43]

The national tariff may also include additional guidance for the above provisions and specifications, and commissioners must have regard to such guidance.[44]

Each of the elements of the system set out above has been agreed between NHS England and Monitor.

1.3 Period for which this national tariff has effect

This national tariff has effect for the period beginning on 1 April 2015 and ending on the later of:

- 31 March 2016
- the day before the next national tariff issued under section 116 of the 2012 Act has effect.

The national tariff presented in this document will therefore have effect for the financial year 2015/16, but if necessary would continue to have effect after the end of that year pending any new national tariff being put in place.

1.4 Structure of this document

In the following paragraphs we describe each of the core sections (together with annexes) of this document. Please note that some of the annexes are Microsoft Excel workbooks.

[40] 2012 Act, section 116(2)
[41] 2012 Act, section 116(4)(b)
[42] 2012 Act, section 116(6)
[43] 2012 Act, section 116(4)(c).
[44] 2012 Act, section 116(7).

In **Section 1**, this introductory section, we describe the statutory consultation process that we put in place to produce this national tariff document. We also outline the structure of this document and supporting documents, and specify the period for which it has effect. Section 1 has one annex:

- **Annex 1a** is a glossary that is relevant for the entire document.

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

In **Section 3** we describe the scope of the payments covered by the '2015/16 National Tariff Payment System' and how the scope might evolve.

In **Section 4** we explain the system of currencies in the payment system, and specify the currencies which will have national prices (including 'best practice tariffs').[45,46] We also outline changes to the currencies for 2015/16. Section 4 includes two annexes:

- **Annex 4a** provides further detail on currency descriptions (such as best practice tariffs)
- **Annex 4b** sets out maternity data requirements and definitions.

Section 4, in combination with the full list of currencies in Annex 5a and the list of excluded high cost drugs, devices and listed procedures in Annex 7b, specifies the NHS healthcare services that are subject to national prices.[47]

In **Section 5**, we specify our methods for determining the national prices of specified healthcare services. Section 5 includes a number of annexes:

- **Annex 5a** is a spreadsheet which lists the currencies that have national prices and the prices themselves, as determined using the methods set out in Section 5
- **Annex 5b** details our data cleansing methodology
- **Annex 5c** sets out the admitted patient care (APC) structured query language (SQL) tariff model handbook
- **Annex 5d** sets out the APC tariff model

[45] Annex 5a contains a complete list of all currencies with national prices.
[46] Best practice tariffs are paid to providers in place of normal tariffs, if best practice guidelines for treatment are followed. 'Best practice' is defined as care that is both clinically and cost effective, and is different for each procedure.
[47] Pursuant to section 116(1)(a) of the 2012 Act.

- **Annex 5e** sets out the outpatient procedures (OPROC) model
- **Annex 5f** sets out the outpatient (OP) attendances model
- **Annex 5g** sets out the accident and emergency (A&E) model
- **Annex 5h** sets out the unbundled services model
- **Annex 5i** sets out the maternity pathway model
- **Annex 5j** sets out the other national prices model
- **Annex 5k** sets out the best practice tariff (BPT) model.

In **Section 6** we specify the nationally determined variations to national prices under section 116(4)(a) of the 2012 Act (for example, the marginal rate rule, top-up payments for specialised services, and the Market Forces Factor), with the exception of the new national variation for specialised services, which appears in Section 8. Section 6 includes two annexes:

- **Annex 6a** is a spreadsheet of Market Forces Factor values
- **Annex 6b** lists the specialist services and providers eligible for top-up payments.

In **Section 7**, we specify the rules that apply to local prices and local variations to nationally determined prices, and the methods used by Monitor for considering local modifications. As part of the rules on local prices, we specify currencies for certain services without national prices (such as mental health currencies) that should be used as the basis for local price-setting.[48] This section does not however contains the local pricing rules for acute specialised services commissioned by NHS England – these are specified in Section 8. Section 7 includes four annexes:

- **Annex 7a** lists the acute currencies specified for local pricing
- **Annex 7b** lists the high cost drugs, devices and procedures which are covered by local rather than national prices
- **Annex 7c** is the mental health clustering tool booklet
- **Annex 7d** lists the national currencies specified for ambulance services.

Section 7 includes explanatory material on locally determined prices as well as the rules themselves.

[48] 2012 Act, section 116(5)

In **Section 8**, we specify a new national variation and a local price-setting rule for specialised services commissioned by NHS England, and specify other rules for the pricing of such services.

In **Section 9**, we set out our rules relating to the making of payments to providers (including billing and monthly activity reporting).

1.5 Supporting documents

In the following paragraphs we describe the supporting documents published alongside this document. Supporting documents are not part of the '2015/16 National Tariff Payment System'; some contain further explanatory information which is best placed outside this document because we may update it more or less frequently than the national tariff, which is currently annual. Some are published jointly by NHS England and Monitor, and some are published by Monitor alone.

Contextual documents

There are three documents that we consider to provide important context to this document, as outlined below.

Impact assessment for the proposals set out in '2015/16 National Tariff Payment System: A consultation notice'

Impact assessment analyses are an important part of policy development. The 2012 Act requires Monitor to carry out and publish an impact assessment in specified circumstances and in particular for any proposals that are likely to have a significant impact on providers, patients or the general public.[49]

Monitor published the impact assessment of our proposals on **26 November 2014**. It covers the proposals for the national tariff in 2015/16 as compared with the 2014/15 national tariff. In addition, it explains how implementation of the proposals will ensure that Monitor discharges its general duties[50] and how Monitor has complied with its duties when developing its proposals.

Guide to the Market Forces Factor

'A guide to the Market Forces Factor' explains the rationale, calculation and implementation of the Market Forces Factor.

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[49] 2012 Act, section 69.
[50] Monitor's general duties are those duties under sections 62 and 66 of the 2012 Act.

Consultation summary

'Consultation on the 2015/16 National Tariff Payment System' summarises our formal consultation process to the '2015/16 National Tariff Payment System: A consultation notice', and outlines the key issues raised by stakeholders and our responses to them.

[The consultation summary will be published alongside the final '2015/16 National Tariff Payment System' document.]

Supporting guidance

The 2012 Act allows Monitor to include supporting guidance within the national tariff and commissioners must have regard to such guidance.[51] Such guidance is included in various sections of this document.

The supporting documents characterised as non-statutory guidance are:

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

[51] 2012 Act, section 116(7).

- ‘Non-mandatory prices model 2015-16’. This contains the model used to calculate non-mandatory prices, as well as the non-mandatory prices list.
- Supporting guidance in the form of a worked example (provided in an excel file format) to applying the new ‘Default 50:50 gain and loss sharing’ rule for acute prescribed specialised services, as set out in Section 8 of this document.

Payment design examples

The payment design examples are intended to inform the development of local payment arrangements. NHS England and Monitor have published examples alongside the ‘2015/16 National Tariff Payment System’. We expect to publish further examples periodically as we research, develop, evaluate and learn from best practice.

Enforcement of the national tariff

‘Guidance on enforcement of the national tariff 2015/16’ sets out Monitor’s enforcement policy, its relationship with the licence conditions and how it will be applied in practice.

Patient leaflet

‘Towards an NHS payment system that does more for patients’[52] explains how the NHS payment system helps to improve care for patients by giving healthcare providers and commissioners (who buy services on behalf of patients) incentives to improve quality and efficiency.

[52] https://www.gov.uk/government/publications/the-nhs-payment-system-a-guide-for-patients

2 Context and strategy

In the context of considerable financial challenges to delivering quality care sustainably, the recently published 'Five Year Forward View'[53] sets out the case for change, a vision for new models of NHS care and priorities for system transformation. 2015/16 in particular will be a very challenging year and will require extraordinary efforts from all providers and commissioners working together to implement necessary changes to care models and to make best use of available funds.

The payment arrangements described in the '2015/16 National Tariff Payment System' have been developed to share the financial risk between providers and commissioners appropriately, given that achieving financial balance for the system overall will be difficult. The arrangements are designed to enable local areas to act to improve models of care and reconfigure services.

In this section we:

- briefly introduce the policy context informing the payment system design
- summarise our strategy for the '2015/16 National Tariff Payment System'.

2.1 Policy context for payment design

Demand for healthcare services continues to grow quickly, reflecting an ageing population, increasing public expectations and the availability of new treatment options.[54] The NHS has to do more to continue to deliver quality patient experiences. This is particularly so for people with multiple long-term conditions and mental health needs. The wrong pattern of services in place can mean missed early intervention or crises resulting from a lack of co-ordination.

This means that, as a whole, the NHS in England needs to move towards implementing innovative and integrated models of care. Across the country, providers and commissioners should be focused on keeping people (especially those who are frail or have multiple long-term conditions) well and out of hospital. For example, several local areas[55] are already well on their way to building new models of care better suited to facing future challenges. The Better Care Fund[56] further sets out an expectation that all local areas must plan for emergency admission reductions.

[53] The 'Five Year Forward View' was published by NHS England in October 2014. Available at: http://www.england.nhs.uk/ourwork/futurenhs/
[54] NHS England's 'Call to Action' details these challenges.
[55] For example, the integrated pioneers, the Accelerate demonstration sites, the Integrated Personalised Commissioning sites, the LTC Year of Care Sites and the Prime Ministers Challenge Fund sites.
[56] http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/

Bringing about such a shift requires action from everyone, starting with leaders making sure that their organisations can respond appropriately, front-line staff systematically adopting evidence-based good practice, and people being supported to confidently manage their own health needs. In some cases, hospitals will need to transform dramatically to be sustainable.[57]

Payment for healthcare services is a fundamental component of the healthcare system and is one of a range of levers for supporting the shift to new models of care. Through the allocation of financial risk and built-in expectations of quality and efficiency, payment design has the potential to support service redesign by adjusting the incentives created. In doing so, unintended consequences may arise, and as such change must be carefully considered. Nevertheless, we believe the payment system can play a part in positively enabling the needed change.

As such, in the context of the care models set out in the 'Five Year Forward View' and the role we believe the payment system can play in bringing these about; Monitor and NHS England have a joint programme of work to support payment reform. A direction of travel for the payment system has built on the vision described in the 'Five Year Forward View'. We will also continue to focus on improving data quality to support the payment system, in particular the collection of accurate and timely patient-level cost, activity and quality data for all care settings. Monitor has set out a vision for costing,[58] including a transition to patient-level costing. The development of such information, and before that a more detailed analysis of reference costs, will allow us to deliver on a key longer term objective of using accurately measured costs to set prices.

In addition to these, NHS England and Monitor have conducted research and development over the past year toward supporting future change. The results of this work are captured in the local payment examples published alongside the '2015/16 National Tariff Payment System', with further such examples forthcoming over the next year. There have also been efforts to develop new currencies for counting and costing that can underpin new payment arrangements. For example, progress is being made to develop currencies for palliative and end-of-life care,[59] as well as children's and adolescent mental health services (CAMHS). These payment approaches will be accompanied by feedback mechanisms for evaluation and refinement.

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57 As evidenced by Monitor's report 'Facing the future: smaller acute providers', available at: https://www.gov.uk/government/consultations/challenges-facing-small-acute-nhs-hospitals

58 *[We intend to publish a direction of travel for the payment system soon after publication of the consultation notice. Monitor is to publish a vision for costing, including a transition to patient-level costing, soon after publication of the consultation notice.]*

59 The findings from the palliative care funding pilots were published by NHS England in October 2014 (see http://www.england.nhs.uk/2014/10/23/palliative-care/). Included was a currency which commissioners and providers may choose to use on a purely voluntary basis. Further testing and development of the currency will take place during 2015/16.

Though we recognise the urgency with which change is needed, moving towards new payment approaches will take time. We anticipate the pace of change will accelerate in coming years with improved building blocks, and more structured and widespread demonstration of new payment approaches, accompanied by feedback mechanisms for evaluation and refinement.

2.2 Our strategy for the 2015/16 national tariff

We expect that 2015/16 will be one of the toughest years financially that the NHS in England has faced. This will be in addition to four years of sustained efforts to meet the efficiency challenge savings target of £20 billion by 2015. With providers working hard to make recurrent savings within existing care models, 2015/16 will require providers and commissioners to work together to identify opportunities for improving system efficiencies.

Our objectives for the ‘2015/16 National Tariff Payment System’ are therefore to:

- maintain financial discipline while promoting quality care in tough conditions
- encourage rapid and widespread transition to new payment designs that better align financial incentives to patient value
- strengthen the building blocks of the national tariff.

In line with these objectives, the following points should be noted in relation to the ‘2015/16 National Tariff Payment System’:

- we adjust price levels to reflect an ambitious but achievable level of efficiency improvement from providers (3.8%), while recognising changes to cost relativities
- we require providers and commissioners to equally share the financial gains and losses for specialised services, unless a more innovative and effective payment approach can be implemented
- we increase the rate at which non-elective admissions are reimbursed over and above agreed baselines to 50% (from 30%), to equally share risk between providers and commissioners
- we strengthen the relationship between payment and outcomes for acute services through extending best practice tariffs (BPTs)
- we re-emphasise the care clusters as the clear default payment arrangement and required reporting unit for all relevant adult mental healthcare
- we support parity of esteem between physical and mental health services including through NHS England’s allocation of £40m for early intervention in psychosis, which is estimated to be equivalent to an uplift of around 0.35% in all mental health services in 2015/16

- we encourage rapid and widespread adoption and testing of new payment arrangements, in support of service reform.

We briefly discuss each of these below.

2.2.1 Prices that reflect efficient costs

In 2015/16 we base prices on average cost relativities from the 2011/12 reference cost collection, while rolling over the cost base from 2014/15. This is a continuation of last year's approach to determining national price levels, while we can investigate further the actual costs of providers. Having updated the 2011/12 costs using cost uplifts and efficiency factors from previous national tariffs, we have applied 1.93% of additional cost uplifts to reflect anticipated changes in pay and drugs costs, other operating costs, unallocated clinical negligence scheme for trusts and capital costs.[60]

We are setting a single efficiency factor for 2015/16 of 3.8%. While this is a challenging target, it is consistent with our analysis, based on data from acute providers, which suggested that this level of efficiency is achievable for the sector as a whole. This factor reflects our expectation that 2015/16 will require effort from all parts of the sector to overcome the financial challenges.

Additionally, to maintain relevance to clinical practice, we have introduced national prices for transcatheter aortic valve implantation (TAVI), and made available non-mandatory guide prices for cochlear implants, complex therapeutic endoscopy and dialysis for acute kidney injury. We have also refined the factors that affect the complexity assigned to levels of antenatal care.

2.2.2 Promoting best value for patients in acute specialised services

In light of the high current rate of growth in expenditure on prescribed specialised services, NHS England and Monitor are introducing a financial gain and loss sharing arrangement that would cover payment arrangements for all acute prescribed specialised services. By sharing financial risk equally, we aim to incentivise providers and commissioners to jointly address the observed high annual increases in prices and volumes for prescribed specialised services, including high cost drugs and devices.

We are introducing a new national variation and new local price-setting rule that requires NHS England teams and providers to start with a default 50:50 gain and loss sharing arrangement applied to a stated base value of nationally priced and non-nationally priced prescribed specialised services. This default would apply

[60] This figure is subject to change before publication of the final National Tariff, as it will need to reflect changes to the data inputs from external sources (eg Department of Health or HM Treasury). See Section 5 for more detail, and subsection 5.5.5 for a summary of data for cost uplifts.

unless more effective local payment arrangements can be agreed that support the adoption of innovative care models; such as lead providers for programmes of care.

2.2.3 From 'leakage' to rigorous transparent accountability

The efficiency factor is intended to be challenging. Indeed, following a number of years of tight finances, both foundation trusts' reported cost improvement plans and studies of achieved productivity gains indicate that trusts are finding it increasingly difficult to meet the challenge. However, although achieved productivity gains have been repeatedly less than the efficiency ask, NHS providers' finances have not deteriorated by the amount that might be expected.

The implication of a shortfall in efficiency improvement combined with finances not deteriorating correspondingly is that some providers and commissioners are taking additional actions other than improving efficiency to protect or improve providers' financial positions. These actions have been historically referred to as leakage. We do not think that the term 'leakage' is helpful and in future our approach will be to focus on the components of the additional actions. Addressing the components in the short run requires improving transparency, accountability and rigour in coding, counting, and costing.

The implementation of prospective changes to counting and coding which constitute departures from national prices may require local payment variations, if they can meet the requirements outlined in the National Tariff rules. In particular, where counting and coding changes have been made, to ensure alignment with the NHS Data Dictionary, a local variation will be needed during the period of notice before the changes come into effect for payment purposes. As with all local payment variations, we expect commissioners to be reporting these in line with standard requirements.

Where appropriate, Monitor will be initiating coding enforcement and compliance investigations. As part of the wider enforcement and compliance programme Monitor will be undertaking work to ensure that local variations are compliant with the National Tariff rules. Commissioners are already required to notify Monitor of all local variations to national prices. Commissioners and providers will be asked to take actions to rectify non-compliance with the national tariff.

NHS England will shortly consult on draft changes to the NHS Standard Contract for 2015/16 including notice period requirements on proposed changes to counting and coding and the management of financial impacts in relation to these. NHS England intends that these changes, combined with the requirement to report local payment variations, will promote financial stability as well as greater transparency. Over time, this will help to bring about a greater degree of standardisation of approach and documentation for counting and coding change proposals, which will in turn enable improved evaluation and assessment of their wider impact.

2.2.4 Sharing equitably financial risk for non-elective admissions

Last year, NHS England and Monitor carried out a substantial review of the 30% marginal rate rule in advance of the '2014/15 National Tariff Payment System'. We concluded that the rule should remain in place as it had helped to contain growth in emergency admissions. We also concluded that the local application of the rule can be improved through the implementation of more transparent reinvestment plans and greater flexibility for updating the baseline.

While anecdotal evidence suggests that a substantial proportion of local areas have negotiated updated baseline values (or even contract-level caps and collars), the rule provides a strong signal that the responsibility for reducing non-elective admissions should be shared between acute providers and commissioners. The Better Care Fund further supports this. In recognition of the need for financial risk to be shared equitably, we are increasing the marginal rate to 50%.

2.2.5 Best practice tariffs

BPTs aim to encourage providers to adopt clinical best practice that is better aligned to patient outcomes. Therefore, in 2015/16, we are introducing a new BPT for heart failure, for which clinical outcomes between patients have varied significantly across England. Furthermore, and in light of progress made towards achieving existing best practice standards, we have increased the target best practice criteria for a small number of BPTs.

2.2.6 Re-emphasising universal reporting of care clusters and use as the clear default for adult mental health payments

In 2015/16 we make clear that the adult mental healthcare clusters are the default payment arrangement for providers and commissioners. Providers must also continue to report all of the data items in the Mental Health Learning and Disabilities Data Set (MHLDDS), as well as mandated quality and outcomes measures. We anticipate that this will help to eliminate unaccountable block contracts, as rigorous reporting on the care clusters should ensure providers are clearly accountable to commissioners for the quality and quantity of care they deliver. This also will help commissioners and providers to make service improvement and investment decisions informed by comparative performance. Consistent with local variation provisions, for payment purposes, commissioners and providers may agree not to use care clusters on a full cost and volume basis. They may continue to share financial risk.

Some local areas are already progressing towards more ambitious payment arrangements that support the integration of mental and physical healthcare, or that promote early intervention and recovery. We encourage these efforts. We are also making available local payment examples that we encourage local areas to consider for use. Further information on these is provided in subsection 2.2.7. Services paid

for via a local payment arrangement must continue to report the mandated minimum dataset items as described above.

NHS England recently announced that it will invest an additional £80million in 2015/16 to enable the introduction of access standards for mental health services. £40 million of this funding is for early intervention in psychosis, for which there is a national commitment for 50% of patients experiencing a first episode of psychosis to start NICE-approved treatment within two weeks. NHS England estimates this is equivalent to an increase in funding for psychosis services of around 15% nationally. These services are subject to local agreement on pricing, and so commissioners should ensure that the actual level of local investment take into account current performance against the NICE standard and access standards to determine the split between price and volume increases. NHS England estimates that applying £40 million to early intervention in psychosis is equivalent to an uplift of around 0.35% in the funding of all mental health services in 2015/16. This uplift will contribute to ensuring parity of esteem between physical and mental health services.

Work is underway to determine the most effective way of ensuring that the remaining £40million has the maximum possible impact in supporting improved liaison psychiatry services and ensuring that 75% of those people referred to an Improving Access to Psychological Therapies (IAPT) service receive treatment within six weeks of referral, and 95% receive treatment within 18 weeks.

2.2.7 Building momentum in service change

For the NHS to be financially sustainable in the medium term, more preventative models of out-of-hospital care are needed. As an example, this could mean a reduction in the breadth of service portfolio for some acute providers, and much greater integration of physical and mental healthcare. To support service change, we are publishing some examples of new payment designs alongside the national tariff as practical help to encourage local areas to test alternative payment approaches. We are keen to encourage the development of new services, and continue to provide for local flexibility to develop payment approaches that support these new services in the ‘2015/16 National Tariff Payment System’.

Service developments will take a number of years, and will need to be accompanied by improvements to data collection and linkage, contracting capabilities and local relationships. In support of these efforts, we are making available local payment examples that describe in detail the rationale and practicalities for implementing payment approaches that support transforming models of care. These have been designed in collaboration with innovative local areas, some of whom will be implementing these arrangements during 2015/16, allowing us to learn from their progress and refine the payment designs.

In recognition that producing examples of alternative payment arrangements is unlikely to be sufficient to see widespread and rapid testing, we will continue to

support local areas by providing practical tools and technical expertise. In addition, through evaluation, we plan to refine the payment designs iteratively, learning as close to real-time as possible, so that the best payment approaches can be rolled out progressively over the next five years.

3 Scope of the '2015/16 National Tariff Payment System'

The Health and Social Care Act 2012 ('the 2012 Act') provides a statutory structure for the NHS payment system, which is significantly greater in scope than the Payment by Results (PbR) system. That structure encompasses the policies and rules for determining the prices of most NHS healthcare services,[61] rather than only hospital-based care.

In this section, we set out how the '2015/16 National Tariff Payment System' will interact with other flows of public funding related to:

- public health services
- primary care services
- personal health budgets
- integrated health and social care
- contractual incentives and sanctions
- devolved administrations.

This is not an exhaustive list of sources of funding to providers that support the delivery of healthcare services. Over time, we will review how the national tariff interacts with each funding flow, including those listed above. As part of our long-term efforts to reshape the existing payment system, NHS England and Monitor will work together to reconsider the scope of the national tariff for future years. It will be based on a shared understanding of where it makes sense for financial incentives to be brought together in a single coherent payment system.

We note the scope of the '2015/16 National Tariff Payment System' has not changed from that outlined in the '2014/15 National Tariff Payment System'.

3.1 Public health services

The national tariff does not apply to public health services provided or commissioned by local authorities or by Public Health England, or to public health services commissioned by NHS England under its 'Section 7A' public health functions agreement with the Secretary of State.[62]

[61] This does not include public health.
[62] 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). For the section 7A agreement, see: Public Health Commissioning in the NHS 2013 to 2014.

3.2 Primary care services

For many NHS primary care services provided by general practices, community pharmacies, dental practices and community optometry practices, payment is substantively determined by or in accordance with regulations or directions, and related instruments, made under the provisions of the National Health Service Act 2006 ('the 2006 Act').[63] To ensure a consistent framework, the '2015/16 National Tariff Payment System' does not apply to payment for such services.

In other cases, the payment for NHS services provided in a primary care setting is not determined by or in accordance with regulations or directions, or related instruments, made under the 2006 Act: the payment is agreed between the commissioner and provider. In such circumstances, the '2015/16 National Tariff Payment System' rules on local price setting apply.

NHS services are becoming more integrated, with some NHS services provided across multiple settings, including primary care. The policies in the '2015/16 National Tariff Payment System' have been designed to work alongside other legal provisions for the payment of NHS services to support better alignment of disparate payment approaches and foster integration.

For example, many clinical commissioning groups (CCGs) have expressed interest in co-commissioning primary care with NHS England area teams. This covers three potential types of co-commissioning:

- greater CCG involvement in influencing commissioning decisions made by NHS England area teams
- joint commissioning arrangements
- delegated commissioning arrangements.

Guidance published by NHS England, 'Next steps toward primary care co-commissioning', helps CCGs and area teams to take forward their preferred co-commissioning model. The guidance includes information on the process for co-commissioning proposals, financial allocations, and legal and governance advice.

[63] 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.

As a result, we envisage that many local areas will seek to align their payment arrangements for core and enhanced primary care services with payment arrangements for other NHS services covered by the national tariff. NHS England is considering a range of contractual options for commissioners and will be sharing progress in the coming months. Several of the local payment examples published alongside the '2015/16 National Tariff Payment System' also indicate how the payment arrangements for integrated care services that include primary care can be designed locally, under co-commissioning arrangements (see section 7.5).

Some GPs conduct simple procedures, which they have been commissioned to perform by CCGs to bring care closer to patients' homes. For the avoidance of doubt, such procedures are not covered by the nationally specified currencies and prices set out in Sections 4 and 5. Instead, and in relation to the '2015/16 National Tariff Payment System', the commissioning of these procedures is covered by the rules for local price-setting, set out in Section 7.

3.3 Personal health budgets

A personal health budget (PHB) is an amount of money identified by a commissioner for securing a person's identified health and wellbeing needs. The use of the PHB is planned and agreed between the individual, their representative, or, in the case of children, their families or carers, and the local NHS team.

From October 2014, adults eligible for NHS continuing healthcare and children and young people eligible for continuing care, have the right to a PHB. The offer of PHBs to others who might benefit will remain at the discretion of commissioners. However, the 2014/15 Mandate[64] sets out that people with long-term conditions who could benefit from a PHB should have the option of one from April 2015. At this time the PHB initiative remains at an early stage in development.

The purpose of a PHB is to maximise patient choice and control, giving patients the flexibility to meet their needs in ways that work for them. Both the services paid for from a PHB and the providers of these services must be identified in a care plan agreed between the individual and the responsible NHS team. The PHB may be used to purchase routinely commissioned NHS services or non-routinely commissioned services and products, such as complementary and alternative therapies. Formally agreeing a care plan ensures that PHBs are used to buy services that:

- are clinically appropriate for the individual
- will meet the assessed need
- can be fully funded by the amount of money available in the PHB

[64] See: 'NHS Mandate 2014 to 2015'

- represent value for money
- are not excluded (as defined in the direct payment for healthcare regulations).

It is important to note that a PHB will not result in additional monies, and it is up to the commissioner to decide how the PHB will be funded. There is no single way to calculate the size of a PHB, as budgets will vary greatly depending on the patient's needs and agreed health goals. Learning from the pilot programme on setting PHBs is available in the personal health budgets toolkit. However, commissioners may choose to use relevant national prices or, where they exist, local prices to inform the indicative budget available to the individual.

There are three options for managing personal health budgets:

- a direct payment for healthcare – an individual or their representative has direct control over a personal health budget and contracts directly with providers or employs assistants directly
- third party budgets – a third party has control over the budget and arranges services and products on behalf of the individual
- notional budgets – the commissioner procures services and products funded by a personal health budget on behalf of an individual.

The individual or their representative can request a particular model of budget that best suits the amount of choice and control with which they feel comfortable.

When a PHB is managed through direct payments for healthcare the payments may be viewed as money in place of NHS services. Direct payments for healthcare are governed by regulations made under sections 12A(4) and 12B(1) to (4) of the 2006 Act. If a PHB takes the form of a direct payment or third party budget, the payments for health and care services agreed in the care plan are not within the scope of the '2015/16 National Tariff Payment System'.

Payment to providers of NHS services from a notional budget is within the scope of the '2015/16 National Tariff Payment System' and will either be governed by a national price as set out in Annex 5a (including national variations set out in Section 6) or a local price. Payment for services where a local price is set has to adhere to the general rules for local pricing in Section 7.4.1. 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 '2015/16 National Tariff Payment System' does not apply.

For clarity, the following are not within the '2015/16 National Tariff Payment System', as they do not involve paying for the provision of healthcare services:

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

- payment for advocacy – advice to individuals and their carers about how to use their PHB
- payment for the use of a third party to manage an individual's PHB on their behalf.

NHS England and Monitor will consider developing further guidance on applying the national tariff to direct payments and third party budgets, as part of the recently launched Integrated Personal Commissioning programme. This programme tests a new model of care that focuses on joining up health and social care for people with complex needs. The programme is exploring how personal care planning and budgets can give people using health and care services greater autonomy to shape their care so that it suits their lives and preferences. The payment approach that will be tested alongside this model of care is capitation-based, which enables health and social care funds to be pooled. An example of a capitation-based payment arrangement for local use accompanies the '2015/16 National Tariff Payment System' (see section 7.5 on local payment examples).

More information about implementing PHBs can be found on the NHS England PHB website. [65]

3.4 Integrated health and social care

The legislative flexibilities that enable joint working between NHS bodies and local authorities in their health and social care functions remain in place following the 2012 Act. These include section 75 of the 2006 Act, which consolidates provisions of the Health Act 1999. This section makes provision for the delegation of a local authority's health-related functions (statutory powers or duties) to their NHS partner, and vice versa, to help meet partnership objectives and create joint funding arrangements. There are several provisions for joint financing, including pooled funds, transfer payments and lead commissioning.[66]

Where NHS healthcare services are commissioned under these arrangements ('joint commissioning'), they remain within the scope of the '2015/16 National Tariff Payment System' even if commissioned by a local authority. Payment to providers of NHS services that are jointly commissioned are governed either by a national price as set out in Annex 5a (including national variations set out in Section 6) where applicable, or by a local price (including a local variation in Section 7.2). Payment for services where a local price is set must adhere to the general rules for local pricing in subsection 7.4.1. Local authority social care or public health services which are commissioned under joint commissioning arrangements are outside of the scope of the '2015/16 National Tariff Payment System'.

[65] http://www.personalhealthbudgets.england.nhs.uk/Topics/Toolkit/
[66] For example, see: Enabling integrated care in the NHS from Monitor.

These provisions can enable integrated care and help reduce gaps and overlaps in health and social care which will benefit patients. The Better Care Fund requires areas to pool a minimum amount of funding using agreements under section 75 of the 2006 Act, which is to be invested in out-of-hospital services that prevent emergency admissions. NHS England has produced more resources to help local areas create pooled budgets and lead commissioning arrangements.[67]

3.5 Contractual incentives and sanctions

Financial incentives and sanctions are important tools that can contribute to improved outcomes through targeting improvements in the quality of health services. Contract sanctions can also ensure basic standards of quality are maintained. In December 2014, NHS England expects to publish the final 2015/16 national Commissioning for Quality and Innovation (CQUIN) scheme and the final 2015/16 NHS Standard Contract, including any revisions to contractual sanctions.

The application of CQUIN payments and contractual sanctions are based on provider performance, after a provider's income has been determined in accordance with the '2015/16 National Tariff Payment System'. To the extent that any sanction changes the amount paid for the provision of an NHS service, the sanction is permissible under the rules relating to the making of payments to a provider under Section 9.1.

3.6 Devolved administrations

The devolved administrations (DAs) are responsible for the NHS in Scotland, Wales and Northern Ireland. The pricing provisions of the 2012 Act cover healthcare services in the NHS in England only. However, there are often instances where a patient from Scotland, Wales or Northern Ireland is treated in England or where a patient from England is treated in one of those countries. The '2015/16 National Tariff Payment System' applies in some but not all circumstances of cross-border provision of NHS healthcare services.

Table 3.1 summarises how the '2015/16 National Tariff Payment System' applies to various cross-border scenarios. 'DA commissioner' or 'DA provider' refers to a commissioner or provider in those countries (eg a local health board in Wales [commissioner], or an NHS trust in Scotland [provider]).

[67] This includes tools to support Better Care Fund Planning.

Table 3.1: How the '2015/16 National Tariff Payment System' applies to devolved administrations

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

In the final scenario above, the commissioner in England is bound to follow the prices and rules in the '2015/16 National Tariff Payment System', but there is no such requirement for DA providers. The commissioner in England may wish or need to pay a price set locally within the country in question, or use a different currency from that mandated by the national tariff. In such cases, the commissioner must follow the rules for locally determined prices (see Section 7). If there is a national price for the service, a local variation would be required to pay a different price to the DA provider or to make a change to the currency. If there is no national price, the rules for local prices should be followed.

Providers and commissioners should also be aware of rules for cross-border payment responsibility set by other national bodies. 'The England–Wales Protocol for Cross-Border Healthcare Services' sets out specific provisions for allocating payment responsibility for patients who live near the Wales–England border. NHS England also provides comprehensive guidelines on payment responsibility in

England.[68] The scope of the ‘2015/16 National Tariff Payment System’ 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 ‘2015/16 National Tariff Payment System’.

68 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

4 Currencies with national prices

Several 'building blocks' support the operation of the payment system for NHS care. They include clinical classification systems and currencies for which there are mandatory national prices in 2015/16.

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.[69] The healthcare services to be specified (that is, the currencies) must be agreed between NHS England and Monitor.[70] In addition, the 2012 Act provides that the national tariff may include rules for determining, where a service is specified in more than one way, which specification applies in any particular case (that is, rules for determining which currency applies where there is more than one currency and price for the same service). This section, supported by Annex 4a (and in combination with the full list of currencies in Annex 5a and the list of high cost drugs, devices and listed procedures in Annex 7b), describes the services that we specify in the '2015/16 National Tariff Payment System', and includes such rules.

In this section, we also explain the main concepts commissioners and providers need to understand for commissioning, recording and paying for, or getting paid for, NHS care in 2015/16. We also explain the concept of 'grouping' using software provided by the Health and Social Care Information Centre (HSCIC).

This section is structured as follows:

- 4.1 defines the concepts of classification, grouping and currency
- 4.2 introduces our policy approach for determining which services have mandated national currencies in the '2015/16 National Tariff Payment System'
- 4.3 describes the currencies that remain unchanged from 2014/15
- 4.4 describes the changes to a small number of currencies in 2015/16. (The detailed methods for determining prices for these currencies are set out in Section 5.)

Further detailed information on the mandated national currencies for national pricing is set out in:

- Annex 4a (additional information on currencies with national prices)
- Annex 4b (maternity data requirements and definitions).

[69] 2012 Act, section 116(1)(a)
[70] 2012 Act, section 118(7)

Information to support the implementation of the currencies is also contained in the 'National Tariff Information Workbook', which is a supporting guidance document in Microsoft Excel format.

We may publish further supporting documentation in due course, depending on user requirements.

4.1 Classification, grouping and currency

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

- a clinical classification system – this enables information about patient diagnoses and healthcare interventions to be captured in a standard format
- a currency – there are too many codes in the primary classification system to form a practical basis for payment so they are grouped into currencies, which are the specified units of healthcare for which payment is made.

In this section, we define what classification, grouping and currency are, and their functions in the process for recording and classifying care for the purposes of payment.

4.1.1 Classification

Clinical classification systems describe information from patient records with standardised definitions and nomenclature. This is necessary for creating clinical data in a format suitable for statistical and other analytical purposes that might be used in, for example, epidemiology, benchmarking and costing. The '2015/16 National Tariff Payment System' relies largely on two standard classifications to process clinical data on acute care. These are:

- the World Health Organization International Classification of Diseases, 10th revision (ICD-10) for diagnoses[71]
- Office of Population Censuses and Surveys 4 (OPCS-4) for operations, procedures and interventions.[72]

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

[71] An ICD-10 5th Edition update is expected in April 2015.

[72] OPCS version 4.7 (which was introduced in April 2014) has been incorporated into the currency design used for 2015/16 prices.

There are other classifications that underpin some areas of the national tariff. For example, the acute renal dialysis currencies use data items available from the National Renal Dataset, and the antenatal and postnatal elements of the maternity pathway system use data items available from the maternity Secondary Uses Services (SUS) dataset.[73]

4.1.2 Grouping

'Grouping' is the process by which diagnosis codes (in admitted patient care only), procedure codes (in admitted patient care and outpatient care), treatment codes (A&E only) and investigation codes (A&E only) included in patient records are mapped to the relevant currency. This is done using grouper software produced by the Health and Social Care Information Centre (HSCIC).[74] The HSCIC also publishes comprehensive documentation alongside the grouper, including a 'Code to Group Workbook' that enables users of the grouper to see how Healthcare Resource Groups (HRGs; described in the next section) are derived and to understand the logic used.

4.1.3 Currency

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. Each service specified is a currency. A currency can take one of several forms. For 2015/16, we use HRGs as the currencies to be used for admitted patient care, A&E, and some procedures performed in outpatients. HRGs are groupings of clinically similar treatments that use common levels of healthcare resources.

The HRG currency system used for the '2015/16 National Tariff Payment System' is known as HRG4[75] and is arranged in 21 chapters, each covering a body system. Some chapters are divided into sub-chapters.

HRG4 introduced the concept of 'unbundled' HRGs, making it possible to report, cost and remunerate the different components of a care pathway separately.[76] This provides a mechanism for moving parts of a care pathway (for example diagnostic imaging or rehabilitation) into different settings.

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

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73 The SUS is the single, comprehensive repository for healthcare data in England which enables a range of reporting and analyses to support the NHS in the delivery of healthcare services. Further detail is available at: www.hscic.gov.uk/sus

74 http://www.hscic.gov.uk/casemix/payment

75 Further information is detailed in the 'Health Resource Group 4 (HRG4) Full Operational Standard'

76 Further information is detailed in the 'Casemix Service HRG4 Guide to Unbundling'

Some currencies describe defined pathways of care, and in 2015/16 these currencies are used as the basis for setting prices for services such as maternity care and cystic fibrosis care.

4.2 Approach to currencies with national prices

In 2015/16, the national prices for admitted patient care, A&E and some outpatient procedures are based on the HRG4 2011/12 reference cost design. This incorporates refinements that better reflect clinical practice in national prices when compared with the '2014/15 National Tariff Payment System' design (which was based on the 2010/11 reference cost design). The refinements result in approximately 200 new or changed HRGs that have a national price. The full set of currency changes are set out in Annex 5a.

In Section 4.3 we describe the currencies for which there are national prices in 2015/16. The arrangements for the local pricing of services with mandatory currencies but no national prices – such as adult mental health and ambulance services – are covered in Section 7 and Section 8.

Our approach sometimes includes specifying services in different ways or developing different currencies for individual HRGs, and attaching different prices (for example, the best practice tariff [BPT] currencies). As well as specifying the currencies, this section (in combination with Annex 4a and Annex 5a) provides the rules for determining the particular cases in which the different currencies and prices should be used.[77]

Details of the methods we have used to determine the national prices of the currencies described in this section are provided in Section 5. The list of the resulting national prices can be found in Annex 5a.

4.3 Currencies for which there are national prices in 2015/16

In this section, we look at the national currencies that will underpin national prices in the NHS payment system in 2015/16. These are summarised in Table 4.1.

[77] Such rules are made under section 116(6) of the 2012 Act.

Table 4.1: Currencies for which there are national prices in 2015/16

Currency type	Section
Admitted patient care	4.3.1
Chemotherapy and radiotherapy	4.3.2
Post-discharge rehabilitation	4.3.3
Outpatient care	4.3.4
Direct access	4.3.5
Urgent and emergency care	4.3.6
Best practice tariffs	4.3.7
Looked after children health assessments	4.3.8
Pathway payments	4.3.9

4.3.1 Admitted patient care

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

Spell-based HRG4 is the currency for admitted patient care. There are usually different national prices for different admission types (eg elective or non-elective), although any given HRG may not necessarily have a national price for each admission type. For admitted patient care, there will continue to be separate prices for non-elective care, and for elective care and day cases combined, although in some cases they may be the same.

After admission, a patient may be under the care of more than one consultant during a spell[78] of care. These are called 'finished consultant episodes' (FCEs). Most patient spells have only one FCE in them, some have two and a small number have three or more.

The price relates to a spell of care based on HRG4 grouping design from the 2011/12 reference costs. It is possible to group each FCE to an HRG, but the overall spell groups to an HRG based on the coding within the spell.

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

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, regardless of the date of admission. Some elements of the care pathway are excluded from national prices, such as critical care and high cost drugs.

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

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

When a patient has more than one distinct admission on the same day (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.

Short-stay emergency adjustments[79] and long-stay payments[80] will remain in place for admitted patient care. These are explained in detail below.

Expanding the scope of the national tariff

In 2015/16 we are introducing a national price for transcatheter aortic valve implantation (TAVI; HRG EA53Z); however, the cost of the devices used in this procedure should be reimbursed separately from the national price.

Short-stay emergency adjustment

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. For 2015/16 we have updated the methodology for calculating the short-stay emergency tariff bands, the inputs into the calculation and the list of HRGs to which the short-stay emergency adjustment applies. Information on the short-stay emergency adjustment methodology can be found in Section 5.4.2. It applies when all of the following criteria are met:

- the HRG is not within the scope of a best practice tariff
- the patient's adjusted length of stay is either zero or one day

[79] 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.

[80] For patients that remain in hospital beyond an expected length of stay for clinical reasons, we allow an additional re-imbursement 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.

- the patient is not a child, defined as aged under 19 years on the date of admission
- the admission method code is 21-25, 2A, 2B, 2C or 2D (or 28 if the provider has not implemented Commissioning Data Set [CDS] version 6.2)
- the average length of non-elective stay for the HRG is two or more days
- the assignment of the HRG has the potential to be based on a diagnosis code, rather than on a procedure code alone, irrespective of whether a diagnosis or procedure is dominant in the HRG derivation.

If all of these criteria are met, the short-stay emergency tariff rather than the non-elective tariff apply, regardless of whether the patient is admitted under a medical or a surgical specialty. Any adjustments to the tariff, such as specialised service top-ups,[81] are applied to the reduced tariff. Annex 5a shows the HRGs to which the reduced short-stay emergency tariff is applicable.

We have identified additional HRGs that will be eligible for the short-stay emergency adjustment in 2015/16. We have also reviewed existing HRGs to identify whether any changes to eligibility would be necessary. This assessment was based on a review of the average length of stay for all standard non-elective HRGs. Table 4.2 and Table 4.3 summarise the proposed changes to short-stay emergency adjustment eligibility for 2015/16.

Table 4.2: Changes to HRG short-stay emergency adjustment percentages

HRG Average length of stay	Existing SSEM* percentages by band	2015-16 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%

* SSEM = short-stay emergency

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

Table 4.3: Changes to HRG short-stay emergency adjustment eligibility

Code	Treatment
Existing HRGs newly eligible for 2015/16	
DZ21J	Chronic obstructive pulmonary disease or bronchitis without non-invasive ventilation, without intubation, with complications or comorbidities (CC)
MB01A	Lower genital tract disorders with CC
QZ17A	Non-surgical peripheral vascular disease with major CC
SA01D	Aplastic anaemia with CC
SA08F	Other haematological or splenic disorders without CC
VA10B	Multiple trauma diagnoses score 24-32, with no interventions
VA10D	Multiple trauma diagnoses score ≥51, with no interventions
WA06W	Other viral illness with CC
WA12V	Complications of procedures with major CC
WA21Y	Other procedures and healthcare problems without CC
Existing HRGs no longer eligible for 2015/16	
QZ13A	Vascular access for renal replacement therapy with CC
QZ13B	Vascular access for renal replacement therapy without CC
QZ14B	Vascular access except for renal replacement therapy without CC
Proposed new HRGs eligible for 2015/16	
HC29Z	Inflammatory spinal conditions
HC32B	Low back pain with CC
HC32C	Low back pain without CC
WA15V	Respite care with length of stay four days or less

Long-stay payment

A long-stay payment on a daily rate basis applies to all HRGs where the length of stay of the spell exceeds a trim point[82] specific to the HRG.

The HRG costs reported in the published 2011/12 reference costs do not include the cost of stays beyond a defined trim point (these are reported separately in reference costs as excess bed days). The trim point is defined in the same way as for reference costs, but is spell based and there are separate elective and non-elective trim points.

In 2015/16 we are continuing with the approach first adopted in 2011/12, whereby there is a trim point floor of five days.[83] For 2015/16, there will be two long-stay payment rates per chapter – one for children-specific HRGs and one for all other HRGs. This approach was first introduced in 2013/14.

If a patient is medically ready for discharge and delayed discharge payments have been imposed on local authorities under the provisions of the Community Care (Delayed Discharges etc) Act 2003, commissioners should not be liable for any further long-stay payment. Secondary Uses Services (SUS) Payment by Results (PbR)[84] will apply an adjustment for delayed discharge when the Discharge Ready Date field is submitted in the CDS, by removing the number of days between the ready date and actual discharge date from any long-stay payment. This is the only circumstance in which long-stay payments may be adjusted. Where the Discharge Ready Date field is submitted, providers will wish to satisfy themselves that local authorities are being appropriately charged.

4.3.2 Chemotherapy and radiotherapy

Chemotherapy

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

Chemotherapy payment is split into three parts:

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

[82] The 'Reference Costs 2011-12' document states that "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."
[83] 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.
[84] http://www.hscic.gov.uk/article/1922/SUS-Payment-by-Results

- unbundled HRGs for chemotherapy drug procurement – these have local currencies and prices
- unbundled HRGs for chemotherapy delivery – these have national prices.

Radiotherapy

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

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

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

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.

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

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

- external beam radiotherapy preparation – this has a national price
- external beam radiotherapy delivery – this has a national price
- brachytherapy and molecular radiotherapy administration – this has local currencies and prices.

Further information on the structure of the chemotherapy and radiotherapy HRGs and payment arrangements can be found in Annex 4a.

4.3.3 Post-discharge rehabilitation

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

Post-discharge national currencies cover an entire pathway of treatment. 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.

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

- cardiac rehabilitation[85]
- pulmonary rehabilitation[86]
- hip replacement rehabilitation
- knee replacement rehabilitation.

For 2015/16, the national prices for these four post-discharge currencies will continue to be mandatory for the care of patients where a single provider provides both acute and community services. Where services are not integrated, the national price does not apply; however, we encourage the use of these prices in local negotiations on commissioning of post-discharge pathways of care.

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.

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

The post-discharge activity and national price will not be identified by the grouper or by SUS. 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.

Further detail on all four post-discharge currencies, their scope and their specific rules can be found in Annex 4a.

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

4.3.4 Outpatient care

National prices for outpatient attendance are based on attendances grouped by TFC categories. A TFC is based on the Main Specialty Code, which describes the specialty within which the consultant is recognised or contracted to the organisation. TFCs record the service within which the patient is treated.[87] There are separate prices for first and follow-up attendances, and in each case also for single and multi-professional attendances.

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,[88] 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.

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

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

Outpatient attendances do not have to take place in hospital premises. Therefore consultant-led outreach clinics held in a GP practice or a children's centre should be eligible 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.

If a patient proceeds to separate attendances with an allied health professional (eg a physiotherapist) following an outpatient attendance, the costs of attendances with the allied health professional are not included in the national price for the original attendance.

[87] TFCs (Treatment Function Codes) 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'.

[88] 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.

Commissioners and providers should use the 'NHS Data Model and Dictionary' to determine the categorisation of outpatient attendance and day-case activity.[89] 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 commissioners include within contracts.

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

Where patient data generates a procedure-driven HRG (that is, not from HRG4 sub-chapter WF[90]), 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 using the relevant outpatient attendance national price.

For TFCs with no national price, the price should be set through local negotiation between commissioners and providers. The national price for any unbundled diagnostic imaging associated with the attendances must be used in all cases.

Diagnostic imaging in outpatients

In 2013/14, separate national prices were set for diagnostic imaging unbundled from the outpatient attendance prices. This change was made to address concerns that there was potential for double payment for imaging if the patient had already accessed imaging services from primary care. It was also felt that paying separately for outpatient diagnostic imaging may support greater use of direct access services, supporting primary care clinicians to make diagnoses without the need for an outpatient referral.

The approach of setting separate national prices for diagnostic imaging in outpatients will continue in 2015/16. These national prices are mandatory, regardless of whether or not the core outpatient attendance activity has a mandatory national price.

[89] 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. The Audit Commission carried out a review on definitional issues in conjunction with the Department of Health and HSCIC.

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

4.3.5 Direct access

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

A new (optional) field was added to the outpatient CDS version 6.2 which can be used to identify services that have been accessed directly.[91]

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 separate diagnostic imaging should attract a payment.

Direct access diagnostic imaging

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

Other direct access prices

There are also national prices for:

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

There is also a non-mandatory price for direct access plain film x-rays, for which information is provided in the ‘Non-mandatory prices model’ supporting document.

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

4.3.6 Urgent and emergency care

For 2015/16, there will continue to be national prices mandated for A&E services and minor injury units, based on 11 HRGs (sub-chapter VB – Emergency and Urgent Care). The A&E currency model has been designed with classifications based on investigation and treatment.

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

For 2015/16, 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.

Services that are provided by NHS walk-in centres, which are categorised as Type 4 A&E services by the NHS Data Dictionary, will not attract national prices. Information on local price-setting can be found in Section 7.

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

4.3.7 Best practice tariffs

This section sets out information on the existing, new and amended BPTs for 2015/16.

The BPT prices can be found in Annex 5a, and information to assist with implementation is provided in Annex 4a.

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

Where a BPT introduces an alternative currency, that currency should be used in the cases described here, and in Annex 4a and Annex 5a.[92]

[92] 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).

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

- avoiding unnecessary admissions
- delivering care in appropriate settings
- promoting provider quality accreditation
- improving quality of care.

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

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

The first BPTs were introduced in 2010/11 following Lord Darzi's review in 2008.[93]

A summary of the full 2015/16 BPT package and its evolution is provided in Table 4.4. For 2015/16, four existing BPTs have been amended. These are day-case procedures, outpatient procedures, endoscopy, and primary hip and knee replacement outcomes. A new BPT is also introduced for 2015/16 for non-elective admissions for heart failure, which is designed to incentivise better adherence to National Institute for Health and Care Excellence (NICE) guidance. Further detail on the new and amended BPTs is included in Annex 4a. The methodology applied in calculating the prices for new and amended BPTs can be found in Section 5.4.

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 5a. These BPTs will relate to a subset of activity covered by the high level HRG. There will be other activity covered by the HRG that does not relate to the BPT activity, and so a 'conventional' price is published for these HRGs to reimburse the costs of the activity unrelated to the BPT.

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

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

Table 4.4: Summary of BPT package for 2015/16

BPT	Introduced	Additional changes since introduction	
Acute stroke	2010/11	2011/12 and 2012/13 2013/14	Increased price differential Currency split to differentiate by patient complexity
Cataracts	2010/11	2013/14	Status changed from mandatory to non-mandatory
Fragility hip fracture	2010/11	2011/12 2012/13	Increased price differential Further increase in price differential and expansion of best practice characteristics
Day-case procedures	2010/11 (gall bladder removal only)	2011/12 2012/13 2013/14 2015/16	12 further procedures added 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	2012/13	Five further procedures introduced

BPT	Introduced	Additional changes since introduction	
	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 2015/16	Flexibility to encourage see-and-treat hysteroscopy Recalculated price for diagnostic hysteroscopy based on an increased transitional target towards the proportion thought to be achievable. Updated the calculation methodology not to apply an implicit efficiency assumption in our proposed prices
Same-day emergency care	2012/13 (12 clinical scenarios introduced)	2013/14	Seven new clinical scenarios introduced
Diabetic ketoacidosis and hypoglycaemia	2013/14		
Early inflammatory arthritis	2013/14		
Endoscopy procedures	2013/14	2015/16	Change to transitional arrangements so that only level 1 accredited units will receive the BPT.
Paediatric epilepsy	2013/14		
Parkinson's disease	2013/14		

BPT	Introduced	Additional changes since introduction	
Pleural effusions	2013/14		
Primary hip and knee replacement outcomes	2014/15	2015/16	National Joint Registry thresholds increased to 85%
Heart failure	2015/16		

4.3.8 Looked after children health assessments

Looked after children[94] are one of the most vulnerable groups in society. Data show that they have poorer health outcomes than other children, with a corresponding adverse impact on their life opportunities and health in later life. One third of all looked after children are placed with carers or in settings outside of the originating local authority. These are referred to as 'out-of-area' placements.

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

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

To address this variability, a currency was devised and mandated for use in 2013/14, including a checklist for the components that must be included in the assessment. The aim was to promote consistency and enable more timely assessments. Non-mandatory prices were also made available for use in 2013/14, and national prices were introduced in 2014/15. For 2015/16 we continue to specify mandated national prices as well as the currency itself. A checklist for implementing the currency is included in Annex 4a.

[94] 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"."

4.3.9 Pathway payments

Pathway payments are single payments that cover a bundle of services[95] 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. Pathway payments therefore aim to promote the greater clinical effectiveness and efficiency that can be gained by organising the pathway of care as a whole.

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

Maternity pathway payment

The maternity pathway payment system, mandated since 2013/14, splits maternity care into three stages: antenatal, delivery and postnatal. A woman chooses her provider for each stage of the pathway, which is identified as the 'lead provider'. Women may have a different lead provider for each of the three stages of the maternity pathway. The commissioner makes a single payment to the lead provider of each stage to cover the cost of all required care. The level of the payment the lead provider receives depends on factors that will affect the extent of care that a woman is expected to require.

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

Further information on the pathway payment approach can be found in Annex 4a and Annex 4b.

By April 2015, the pathway payment system will have been mandatory for two years. A national variation has been operational since April 2013 to allow any risks associated with the new pathway payments to be shared between providers and commissioners. For 2015/16, this national variation has been removed, as we believe there has been a sufficient period of time for the sector to adapt to this payment approach.

[95] 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.

Cystic fibrosis pathway payment

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.

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.

4.4 High cost drugs, devices and listed procedures

Several high cost drugs, devices and listed procedures are not included in the national currencies and are therefore not reimbursed through national prices. Instead they are subject to local pricing in accordance with the rules set out in Section 7. For the ‘2015/16 National Tariff Payment System’, we have updated the list of drugs, devices and procedures using the same criteria used in previous years.[96] High cost drugs, devices and listed procedures meet standard criteria, and we have taken advice from providers, commissioners, the NICE and other experts to assure which drugs and devices are included on the list. Annex 7b sets out details of the high cost drugs, devices and listed procedures for 2015/16. The related local pricing rule is set out in subsection 7.4.3.

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

5 Method for determining national prices

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

Under our rules for locally determined prices, where there are already local prices for services without a national price, commissioners and providers should have regard to the cost uplift factors and efficiency requirements for national prices in the '2015/16 National Tariff Payment System', when setting those local prices for 2015/16. Further detail is set out in Section 7 rather than this section.

This section is structured as follows:

- in 5.1 we explain the principles that have informed our method for determining national prices
- in 5.2 we describe our overall approach of using a refreshed tariff model (with updated inputs) as a base to calculate the 2015/16 prices. We refer to this as a 'modelled approach'
- in 5.3 we describe in more detail the key data and methodology underlying the modelled approach
- in 5.4 we discuss our methods for determining the national prices of new or altered currencies in the '2015/16 National Tariff Payment System'
- in 5.5 we discuss the method and data sources used for calculating the cost uplifts for 2015/16 to reflect inflation and other cost pressures on providers
- in 5.6 we explain the efficiency requirement, which indicates our expectations for how much more efficient we expect providers, in aggregate, can be in 2015/16
- in 5.7 we summarise the changes to national prices.

This section has a number of associated annexes:

- Annex 5a, which sets out the national prices for 2015/16, as determined using the methods described in this section
- Annex 5b, which sets out the data cleansing method used for the 2015/16 national tariff
- Annex 5c, which sets out the Admitted Patient Care (APC) Structured Query Language (SQL) tariff model handbook
- Annex 5d, which sets out the APC tariff model
- Annex 5e, which sets out the Outpatient Procedures (OPROC) model
- Annex 5f, which sets out the Outpatient Attendances (OPATT) model
- Annex 5g, which sets out the Accident and Emergency (A&E) model
- Annex 5h, which sets out the unbundled services model
- Annex 5i, which sets out the maternity pathway model
- Annex 5j, which sets out the other national prices model
- Annex 5k, which sets out the Best Practice Tariff (BPT) model.

5.1 Main principles

Under the Health and Social Care Act 2012 (the '2012 Act'), NHS England and Monitor have joint responsibility for the payment system, including setting national prices for particular services. This section outlines the main principles we have applied in setting national prices for the '2015/16 National Tariff Payment System'.

Our aim is to set unit prices that encourage better patient care within the existing healthcare budget. We have two principles that support this aim, and which furthermore reflect our statutory duties and commitment to apply best practice in pricing regulation. Our two main principles are that prices should:

- reflect efficient costs
- provide appropriate signals.

We explain each principle below.

5.1.1 Prices should reflect efficient costs

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

In many sectors of the ecomomy, competition between providers of a good or a service has tended to lead to downward pressure on prices and improvements in the quality of the product or service. This occurs as producers seek to attract customers to the good or service they produce and away from rival producers. Typically this downward pressure on prices continues until the price of the good or service is in line with the efficient costs of its provision. These competitive forces are generally recognised to have brought significant benefits to consumers.

However, there are other parts of the economy where, because of particular features of the sector, there is less likely to be competition between providers and therefore limited or no downward pressure on prices. For example, some sectors are considered to be 'natural monopolies' where it makes sense to have only one provider of the good or service. In these sectors, because prices charged by providers would not be subject to the competitive pressures that are a feature of most sectors of the economy, regulators may intervene to constrain, in some way, how the provider of that service operates and the prices it can charge.

Consistent with our duties, and in particular our duty in relation to ensuring that prices for providers are set at a fair level for providers, we consider that prices, as in other parts of the economy, should reflect the efficient costs of provision.[97]

This means that prices should reflect the costs that a reasonably efficient provider ought to incur in supplying healthcare services at the quality expected by commissioners. In turn, providers can recover their efficiently incurred costs (which will typically include provisions for the depreciation and financing of capital expenditure as well as for necessary operating expenditure). This can be particularly important in the long term, as it enables providers to invest in new equipment and innovation.

[97] 2012 Act, section 119(1).

In setting prices in the '2015/16 National Tariff Payment System' we need to balance, among other things, the need for prices to reflect efficient costs with the need for prices to be set in a way that is reasonably simple and transparent. A highly complex system, with many prices for different types of services and patients, may reflect underlying costs more accurately than a system with fewer prices. However, such a system is likely to be hard to understand and costly to administer. A simpler approach to setting prices, reimbursing the total costs of all services, would be easier to understand and operate, and more cost effective to administer. However, it is likely to less accurately reflect the underlying costs of individual services.

5.1.2 Prices should provide appropriate signals

When prices reflect efficient costs they signal to buyers, producers and other market participants what it costs to produce a good or service. In the national tariff, prices signal to commissioners the average costs of each service they commission from providers. They also signal the cost of providing NHS services more generally; this may, for example, be of interest to the Department of Health (DH).

National prices, and the payment system in general, should indicate resource costs to commissioners, providers and other interested stakeholders (eg the DH) to inform crucial decisions about NHS services. This is consistent with our duty to protect and promote the interests of people who use healthcare services.[98] We want the national tariff to enable better patient care for a given budget. This can happen in two main ways:

- the payment system encourages commissioners to make the most effective use of available budgets (that is, it enables commissioners to make the best decisions about the mix of services likely to offer the highest value to their local population)
- the payment system incentivises providers to reduce their unit costs by finding ways of working more efficiently.

[98] 2012 Act, section 62(1).

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

- setting prices too high may disadvantage patients by reducing the volume of services that commissioners can purchase within a fixed budget. High prices could also reduce the incentive for providers to find cost savings, which would negatively affect patients in the longer term
- setting prices too low can be just as detrimental to patient interests, particularly in the long term, because:
    - providers may not be fully compensated for the services they provide, potentially leading to withdrawal of services, compromise on service quality, and/or underinvestment in the future delivery of services
    - commissioners may 'over purchase' low-priced services, at the expense of other services, because they may perceive the value for money of those services to be better than it actually is.

The relationship between cost and quality is complex; however, it is plausible that some providers are able to provide both higher quality and lower cost services.

A further caveat to note is that, relative to many other sectors of the economy, the healthcare sector has some unusual features that are likely to affect the pricing system as a whole. For example, those benefiting from (and increasingly choosing) the service – ie patients – do not pay for that service directly. As such, and unlike many other sectors of the economy, price signalling inevitably reaches the service user only indirectly.

There are also often significant information asymmetries between patients, commissioners and providers. This means, for example, that it is sometimes difficult for patients to know what treatment and service options are available. Because of this, unit prices should only be considered as one feature of the overall payment system. Other common features for payment systems in health (often at a more aggregate level) include quality incentives and sanctions, and measures for sharing unexpected cost increases. It is not uncommon, for example, for payments in health to be subject to a payment cap to encourage appropriate provider behaviour.

5.2 Overall approach

We are setting national prices for 2015/16 based on a refreshed tariff model. This is different from how we set the 2014/15 national prices, which were based on a rollover approach.[99] The methodology for the tariff model for the '2015/16 National Tariff Payment System' prices follows closely the methodology used by the DH Payment by Results (PbR) team for the 2013/14 national tariff, except that we have, where possible, updated the input data used.[100] We refer to this as a 'modelled approach', to reflect the fact that we have used a full model set (ie several models) with updated data to calculate most prices for the '2015/16 National Tariff Payment System'.

We consider that a modelled approach for national prices is most suitable for the '2015/16 National Tariff Payment System'*.* It enables us to use more up-to-date cost data in setting national prices.

In summary, our modelled approach for the '2015/16 National Tariff Payment System' involves*:*

- the currency specification as set out in Section 4 of this document
- the 2013/14 DH PbR method for price setting with updated inputs
- prices calculated on the basis of on 2011/12 reference costs
- Hospital Episode Statistics (HES) activity data from 2011/12 grouped by Health and Social Care Information Centre (HSCIC) to the appropriate Healthcare Resource Group (HRG) design
- where possible, set prices for new or modified HRGs using the 2013/14 DH PbR method.

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[99] For the 2014/15 national tariff we used 2013/14 prices as the base and adjusted those prices generally for cost pressures on providers and expectations for improved efficiency

[100] For a description of the 13/14 PbR method, please see 'Payments by Results, Step by Step Guide: Calculating the 2013/14 National Tariff'. It was not always possible to exactly replicate the PbR method. Where we have significantly deviated from the PbR method we set this out in this document. For example we have simplified some of the calculation processes.

While we have, in general, based our modelled approach on the 2013/14 DH method, we have made some changes to it. In summary, these changes are to:

- apply a comprehensive set of data-cleaning rules to the 2011/12 reference cost data to improve the quality of the cost data in the model
- apply a transparent process for any manual adjustments to modelled prices
- apply a scaling factor and smoothing factor to prices
- for prices for which a 2013/14 PbR method was not available we either:
    - used the rollover approach applied in the 2014/15 national tariff (this approach calculates 2015/16 prices using the 2014/15 tariff prices as a base and applies an inflation, efficiency and, where applicable, a Clinical Negligence Scheme for Trusts (CNST) factor to them to arrive at the 2015/16 prices)[101]
    - developed new models that were designed to follow, as closely as possible, the principles of the 2013/14 DH PbR method. An example of this was the calculation of the Short Stay Emergency (SSEM)[102] tariff.

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[101] Section 5.2 of the '2014/15 National Tariff Payment System' states:

'2014/15 national prices (for currencies that are unchanged) are calculated by using 2013/14 prices as the base and adjusting those prices generally for:

- cost pressures on providers; offset by
- our expectations for improved efficiency on the part of providers.

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

[102] See 'Reduced Short Stay Emergency Tariff' in Annex 5A

We note that in implementing the PbR method we have in some cases deviated from the exact implementation of the method. For example we have used different software packages for some calculations (SQL) than were used by the PbR team (Access), but in all cases we aimed to replicate the PbR methodology – with the main changes we made to the PbR method set out in this section. The SQL code can be found as part of the Excel tariff calculation models – see Annex 5c.

5.3 Modelling approach

In this section we explain in broad terms the method we have used for setting the 2015/16 tariff prices. To assist reader understanding we have outlined in brief below the 2013/14 DH PbR method and the main updates to the 2015/16 tariff method by comparison.

The **2013/14 DH PbR** method calculates the tariff prices very broadly in the following way:

- Tariff prices are first derived from the total costs and total activity per HRG as reported in the 2011/12 reference cost dataset.
- The tariff prices are then adjusted from the 2011/12 price base into the 2015/16 price base by applying efficiency, inflation and CNST adjustment factors for the four-year gap between the 2011/12 price base and the 2015/16 tariff year.
- Manual adjustments are performed to minimise the risk of setting implausible tariffs (eg tariffs that have illogical relativities – ie where the price for a more complex treatment is lower than for a less complex treatment without good reason).

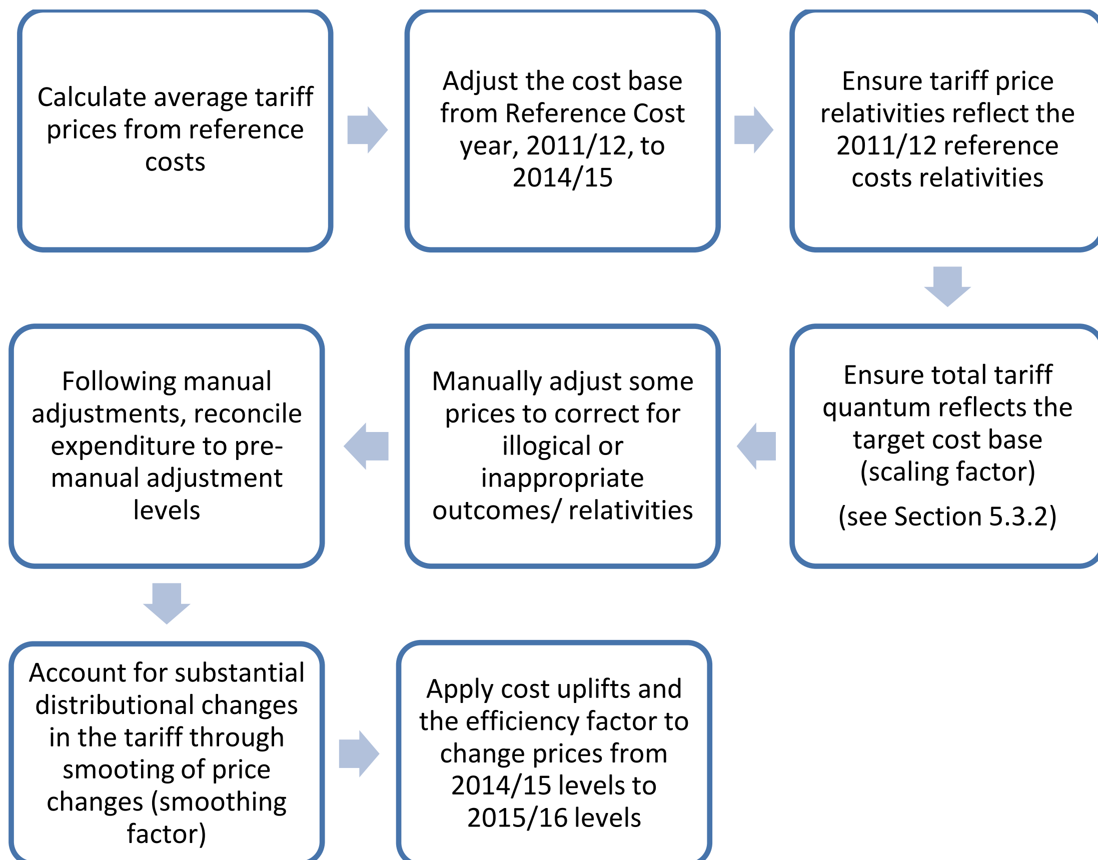
The main updates in **the 2015/16 tariff method** compared to the 2013/14 DH PbR method are:

- Prices are adjusted to ensure that they reflect the price relativities of the 2011/12 reference cost dataset, but at the same time reimburse the same total quantum as the 2014/15 tariff (when using 2012/13 HES activity). We achieve this through the application of a scaling factor to the prices derived from the 2011/12 reference cost base. This is our initial target cost base (ie a 2014/15 cost base), which is later adjusted to 2015/16 (using uplifts and efficiency adjustments, as outlined in the final point below)

- Manual adjustments are performed with a final reconciliation to ensure that the manual adjustments do not change the total quantum reimbursed.
- A smoothing factor is applied to limit year on year volatility in the quantum reimbursed for each chapter in the admitted patient care (APC) and outpatient procedures (OPROC) tariffs. Smoothing does not affect the total quantum.
- Cost uplifts, efficiency factor and CNST are then applied to adjust prices from reflecting the initial 2014/15 target cost base to a 2015/16 cost base.

The chart below illustrates the overall method for the 2015/16 national tariff.

Figure 5.1 Overall method of the 2015/16 national tariff



Note: As a final step, the prices were rounded to the nearest pound to produce the final national prices set out in Annex 5a. A similar approach was used in the 2013/14 DH PbR method.

The Admitted Patient Care (APC) SQL model handbook and the tariff models are attached as annexes to this section and provide further details on our modelling method.[103]

We set out below in more detail the data updates and main changes we made to the 2013/14 DH PbR method.[104]

5.3.1 Reference cost inputs

Reference cost dataset used

We use 2011/12 reference cost data[105] in the 2015/16 tariff. Although more up-to-date reference cost data are available to us (2012/13 reference cost data), we nevertheless use the 2011/12 reference cost dataset because it is very closely aligned with the currency design[106] of the 2015/16 tariff. Basing prices on 2012/13 reference costs would require remapping the costs onto the 2015/16 currency design. Our initial analysis of such a remapping identified several risks and challenges. For example, our analysis indicated that a disproportionately large number of 2012/13 activity grouped to the UZ101Z (non-priced) HRG code when grouped by the 2011/12 reference cost grouper.

Reference cost data cleaning

One of our main objectives is to create a more stable and reliable tariff and reduce unexplained tariff price volatility.

We think that using cleaned data (ie raw reference cost data with a number of implausible records removed) will, over time, reduce the number of illogical cost inputs (for example, fewer very-low-cost recordings for a particular service and fewer illogical relativities.[107]) This, in turn, should reduce the number of modelled prices that require manual adjustment and should

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[103] See Annexes 5c to 5k.

[104] For a description of the 2013/14 PbR method, please see 'Payments by Results, Step by Step Guide: Calculating the 2013/14 National Tariff'.

[105] See: 'NHS reference costs: financial year 2011 to 2012'.

[106] We have used the HRG4 currency system (see Section 4 of this document for further details).

[107] An illogical relativity is where the costs of performing a more complex procedure is lower than the cost of performing a less complex procedure (without good reason).

therefore increase the reliability of the tariff. We think this benefit outweighs the disadvantage of losing a number of data points as a result of the data cleaning process.

We have made some changes to the reference cost data-cleaning processes that were previously used in the 2013/14 PbR method. The new reference cost data-cleaning rules are based largely on recommendations provided by Deloitte[108] indicating that when implemented they would marginally reduce unexplained tariff price volatility from year to year. The new data-cleaning rules exclude:

- outliers from the raw reference cost dataset detected using a statistical outlier test known as the Grubbs test (also known as the 'maximum normed residual test')
- providers who submitted reference costs more than 50% below the national average for more than 25% of HRGs and who at the same time also submitted reference costs 50% higher than the national average for more than 25% of HRGs submitted
- providers who submitted reference costs containing more than 75% duplicate costs across HRGs and departments.

We have decided not to follow the recommendations in full. This was because we encountered some technical issues in the implementation of some of the rules. For example, it proved more difficult than anticipated to identify the full set of potential illogical relativities. In particular we have:

- not followed the recommendation to exclude providers with at least five unit cost submissions below £5 and at least 10 unit cost submissions above £50,000, subject to an average unit cost check
- not followed the recommendation to exclude providers who submitted reference costs containing more than 15% of unit costs that exhibited illogical relativities.

For the 2015/16 tariff we are cleaning only reference cost data for the model for APC.

[108] See the independent research paper on the 'NHS National Tariff Payment System 2015/16: engagement documents' webpage.

Applying these rules to the reference costs dataset we use to set national prices for admitted patient care has led to a small percentage of reference cost data records being removed to improve the quality of the dataset. The most significant effect was to remove all admitted patient care reference cost data submitted by a small number of providers. Further detail on the data-cleaning method is provided in Annex 5b.

5.3.2 Establishing the appropriate cost base for national prices

One of our price-setting principles is that prices should reflect efficient costs. That means we must try to ensure that the costs on which prices are based are appropriate for setting national prices.

Consequently, before applying a prospective set of cost uplifts and the efficiency factor, a key step of the price-setting models (both current models, and the DH's past models) is reconciling the modelled prices to an overall level of expenditure. Absent any adjustments, that overall level would normally be the latest reference cost 'quantum' uplifted to the beginning of the tariff period (in this case the 2011/12 reference cost quantum uplifted to the 2014/15 using historic uplifts and efficiency factors). In other words, we would ensure that when national prices are multiplied by reported activity for 2011/12, the overall sum of expenditure matches the total costs reported under the 2011/12 reference costs, uplifted to 2014/15 using historic uplifts and efficiency factors.

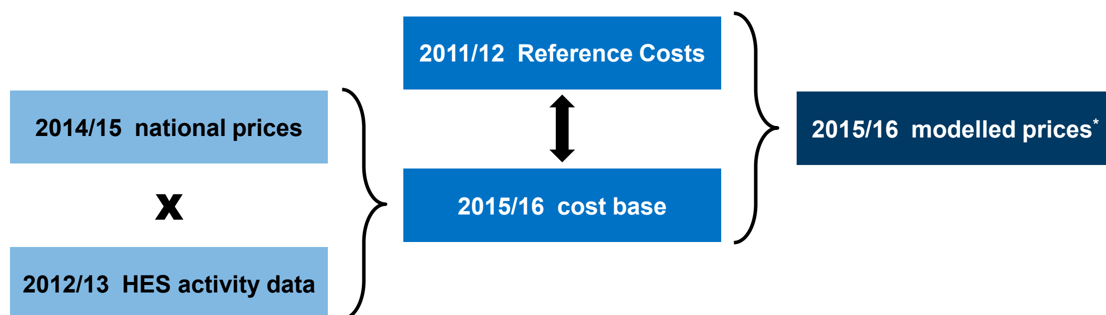
However, there may be reason to reconcile to a level of expenditure other than the reference cost quantum.[109] For example, we may choose to exclude costs that can be directly associated with sources of revenue other than prices paid in accordance with the national tariff. Further, it may also be appropriate to exclude costs that would normally be remunerated through national prices, but where there is evidence that they are likely to be remunerated through some other source (for example, these could include CQUIN payments or winter monies). We have consulted on this issue in the 'Tariff Engagement Document' (TED). Stakeholders generally recognised that significant further work needs to be carried out before a clear policy in this area can be developed.

[109] For example, past national tariffs applied an 'affordability adjustment' and reconciled prices to a level that was typically lower than the reference cost quantum. See: 'Payments by Results, Step by Step Guide: Calculating the 2013/14 National Tariff'.

We considered reported 2011/12 reference costs and evidence on the types of adjustments we might need to make. We concluded that it was not possible to accurately identify and quantify an appropriate set of cost adjustments in the time available to develop proposals for the 2015/16 national tariff. Therefore, the approach we decided to adopt for the 2015/16 national tariff is to reconcile prices to the level of expenditure that would have been achieved if 2014/15 national prices were used. Specifically, modelled prices are based on the product of 2014/15 national prices (the latest available set of national prices) and 2012/13 HES data (the latest available information on activity and volume of care provided).

While the cost base (and therefore price levels before the application of the efficiency and cost uplift factors, or any smoothing adjustments) reflects expenditure under 2014/15 prices, price relativities – differences in prices relative to one another – are based on prices modelled from 2011/12 reference cost. This is illustrated in Figure 5.2.

Figure 5.2: Illustration of determining of cost base and its application in modelling national prices



* Before the application of the efficiency and cost uplift factors, or any smoothing adjustments

There are a number of benefits of this approach. In addition to its simplicity and transparency, this approach provides for overall stability in the sector, as expected total expenditure would reflect the current year's level before being adjusted for cost uplifts and the efficiency factor. As such, this approach reflects the level of expenditure the sector is already operating under. However, the approach introduces information from a number of years into the price-setting methodology and, therefore, is more complex than simply basing national prices entirely on the information contained in 2011/12 reference costs. As such, this approach has been designed as a transitional arrangement for 2015/16. We aim to improve the measurement of the

appropriate cost base and intend to develop an enduring approach, with input from the sector, for 2016/17.

5.3.3 Equivalence of adjustments across points of delivery

In past tariffs, adjustments made when establishing the cost base for national prices varied across points of delivery. For example, historic adjustments made on the cost base for accident and emergency (A&E) prices were relatively greater than those for admitted patient care (APC) prices.

Starting with the 2015/16 national tariff, any adjustments made in establishing the appropriate cost base for national prices, which cannot be directly related to a specific point of delivery, will be applied equally across all points of delivery. This is to ensure equal treatment of all services.

Consequently, in 2015/16 prices for services where the adjustment was previously greater, such as A&E, will increase relative to those services where previous adjustment was smaller, such as APC. The effect of this change is discussed in our impact assessment.

5.3.4 HES activity data inputs

The second key input for the tariff model apart from reference costs is the HES activity dataset, which provides us with the number of treatments or procedures that have been performed by providers. The HES activity dataset is needed for the APC tariff because it is reimbursed on a spell basis, while the activity data contained in the reference cost dataset is based on finished consultant episodes (FCEs).

For the national prices we have used 2011/12 HES data grouped by HSCIC (casemix) using the 2011/12 (HRG4) reference costs grouper. Although more up-to-date activity data are available to us (the 2012/13 HES data), we nevertheless used the 2011/12 HES dataset, because the 2013/14 PbR method aligns the HES dataset from the same year as the reference cost dataset. We set out the reasons for using 2011/12 reference cost data for the calculation of the national tariff in section 5.3.1.

5.3.5 External review

An external expert was commissioned to review the tariff calculation models developed for setting the 2015/16 national tariff, as recommended by HM Treasury best practice guidelines. As a result a number of minor formula

and code changes to the tariff calculation model were made where the review identified clear technical errors.

5.3.6 Manual adjustments

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 (eg tariffs that have illogical relativities). We have broadly followed this approach for the 2015/16 national tariff. As such, after having modelled draft national prices on the basis described earlier, we have used the following process for determining manual adjustments in the 2015/16 national tariff:

1. We made a set of manual adjustments following feedback on draft tariff prices:
    a. We made several manual adjustments following a review of draft modelled prices by HSCIC's expert working groups of clinicians before publication of the TED
    b. We made further manual adjustments following stakeholder comments on the draft prices published in the TED.
2. We made manual adjustments as were agreed through our joint governance process
3. We made further manual adjustments on an ad hoc basis where this seemed to be appropriate (for example where we came across an illogical relativity)
4. We have adjusted prices, so that the total quantum reimbursed is the same before and after the manual adjustment process. For the APC tariffs we have done this on a chapter by chapter basis, for the unbundled tariff on a subchapter basis and for the OPROC and outpatient attendance (OPATT) tariffs we have done this on the basis of all prices (ie the entire model).

We have published details of all the manual adjustments we made as part of the tariff models (see Annex 5d through Annex 5k)

For the majority of tariffs we made a number of specific manual adjustments. However, we note that in some instances the required number of manual adjustments were more widespread. For example, for Chapter H (the

musculoskeletal system chapter), following the expert working group review, we received a large number of proposed adjustments, affecting the majority of the chapter. Further, as part of our sector engagement, we received extensive stakeholder comments regarding both the suitability of reference costs as inputs into the pricing process for Chapter H, and the appropriateness of price relativities set out in the TED.

The combination of the volume of manual adjustment proposals and stakeholder comments raised sufficient concerns regarding the suitability of modelled price relativities that we decided to roll-over the 2014/15 price relativities for this chapter. We note, however, that while this action changes relative prices within Chapter H from those in the TED, it does not change the total amount of revenue flowing to Chapter H.

Similar adjustments were also made for Chapter E, renal dialysis (in the BPT) and for the unbundled chemotherapy tariffs. For more detail – see the tariff models in Annex 5d through Annex 5k.

5.3.7 Accounting for substantial distribution changes in the tariff

As described above, for the 2015/16 national tariff we are moving forward from setting the national tariff based on a rollover methodology to a modelled approach. The modelled approach is based on that previously adopted by the DH PbR team but it is not identical.

A key task in the modelling approach is to update the inputs used in calculating prices, notably reference costs and activity levels. When taken alongside changes in the modelling approach, updates of these inputs (particularly reference costs) lead to modelled prices that are significantly different from last year in a number of areas. As such, we undertook a manual adjustment process designed to limit excessive levels of volatility in prices and to correct inappropriate price relativities (see above section).

The manual adjustment process results in prices being scaled up or down such that the expected revenue resulting from the tariff reflects the cost reported on a chapter-by-chapter basis. This ensures that the adjustment process does not result in an inadvertent redirection of funds between chapters.

However, in addition to a variation in individual prices, the change to a modelled approach and the update in reference costs and activity levels has resulted in changes in revenue flows to different chapters. Some of these

changes may have significant impact on specific trusts (for example specialist trusts), or on revenue flows to specialties within trusts.

To address these significant distributional changes in the tariff, we adjusted prices so that the effect of new prices, when compared to 2014/15 prices, on distribution of funding across chapters is dampened – ie we adjusted the 'quantum change' between chapters. We made these adjustments to admitted patient care and outpatient procedures prices. However, we retained a proportion of the modelled price change in keeping with the cost signals. We describe this below.

The quantum change can be separated broadly into changes due to:

a. 2015/16 cost uplifts and the efficiency factor
b. changes in funding across different points of delivery
c. movements of activity volumes between chapters
d. changes in reference costs
e. changes in pricing method.

We did not adjust prices for effects described in (a) to (c) above as:

- removing the effects of these factors would be contrary to the objectives of the national tariff
- removing past quantum adjustments that varied across points of delivery promotes more cost-reflective pricing
- removing volume changes between chapters does not of itself affect payments made to trusts or specialities for activity, as activity is merely reimbursed under different chapters (or points of delivery).

We did, however, make adjustments to account for points (d) and (e) as:

- reference costs are recognised as being volatile and it is unclear whether one year's reference cost is more appropriate than another's. Allowing prices to vary fully with reference costs, even at the total chapter level, may cause not only excessive price level volatility, but also greater uncertainty over whether prices reflect 'true' costs
- in common with other economic regulators across the economy, we expect to make sequential refinements to the tariff methodology to

reflect the underlying conditions facing providers. There is the potential that any such alterations may disproportionately affect certain providers or certain specialities. While we wish to preserve some of these changes in full (such as the change due to removal of previous differential cost adjustments), we recommend that others are smoothed over a period of time to allow the sector time to adjust to these changes.

We have symmetrically made adjustments for those distributional effects identified in (d) and (e) above (ie we adjusted both increases and decreases in revenue equally). We have set a fixed rule that outlines the adjustments we built into the model when addressing these changes across chapters. As this is the first time Monitor and NHS England are publishing a modelled tariff it is appropriate to minimise disruption to the sector due to the new pricing approach. Therefore, this rule is to only allow 20% of the quantum change due to methodology and reference cost changes (points (d) and (e) above) to flow through to 2015/16 pricing. This will allow for a transition towards cost-reflective prices and revenue distributions across chapters over a five-year period, as well as allowing for some smoothing of reference cost volatility.

5.4 National prices of new or altered currencies

As set out in Section 4, the 2015/16 tariff introduces approximately 200 new or changed currencies (ie HRGs) that require one or more national prices. We have set the prices for these HRGs in the same way that prices are set for HRGs that already have a national price, with a few exceptions, which only affect the non-mandatory prices.

5.4.1 Prices without a fully modelled price – non-mandatory prices

For a number of new or amended currencies we have not been able to provide a fully modelled price. This was only the case for non-mandatory prices – ie illustrative prices published as a point of reference, rather than national prices which are mandatory. Non-mandatory prices are formally not part of the national tariff under the 2012 Act – we refer to them here for information only.

We have provided illustrative prices for these new or amended currencies in the non-mandatory tariff model.[110] This means that, although we display prices for these currencies in the non-mandatory section, commissioners and providers should only use them as a point of reference. This is because the associated tariff models are still in the development stage. We encourage commissioners and providers to make their own assessment of the suitability of the associated tariff models in their local negotiations.

Listed below are the those new or amended currencies in the non-mandatory tariff model which use 2012/13 reference costs as the basis for their design. This is due to better identification of the activity, which has a material impact on the cost associated with these prices. Due to the change in design, using the 2011/12 reference costs as the basis for their price would be incorrect, and therefore the 2012/13 reference costs are used.

Table 5.1: New and amended currencies in the non-mandatory tariff model (using 2012/13 reference costs as a basis for design)

Code	Name
CZ25A	Unilateral Cochlear Implant
CZ25B	Bilateral Cochlear Implants
FZ89Z	Complex Therapeutic Endoscopic Upper or Lower Gastrointestinal Tract Procedures
JC46Z	Photodynamic Therapy
JC47Z	Phototherapy
LE01A	Haemodialysis for Acute Kidney Injury, 19 years and over
LE01B	Haemodialysis for Acute Kidney Injury, 18 years and under

[110] Non-mandatory prices are not part of the national tariff under the 2012 Act and the non-mandatory tariff model is not part of the method for determining binding national prices under that national tariff. Objections to the non-mandatory tariff model are therefore not objections which can trigger referral to the Competition and Markets Authority.

For the HRGs listed above, the price setting methodology is broadly similar to Admitted Patient Care (APC) tariff prices. There are, however, a number of differences, for example:

- we are using 2012/13 reference costs (rather than 2011/12 reference costs)
- we are using spell-based reference costs instead of FCE based reference costs. The APC tariff uses FCE-level reference costs and converts FCE costs to spell costs using HES data. This step was omitted to simplify the calculation process as the information on spell level costs was directly available from reference costs. Since LE01A

  and LE01B activity and cost are collected on a sessional basis, for these HRGs this second step was not required.

We note that for Complex Therapeutic Endoscopic Upper or Lower Gastrointestinal Tract Procedures (FZ89Z) the currency design would map activity away from HRGs FZ24A, FZ24B and FZ24C. As a result, some of the costs contained within FZ24A, FZ24B and FZ24C would now be contained in FZ89Z. A method has been provided within the non-mandatory model to scale the initially calculated values for FZ24A, FZ24B and FZ24C from 2011/12 reference costs to reflect this reallocation of costs. The new prices for FZ24A, FZ24B and FZ24C have been reflected within the APC model as a manual adjustment.

The model for-non mandatory prices is provided as a supporting document.

5.4.2 Amendments to the maternity pathway

As explained in Section 4, for the ‘2015/16 National Tariff Payment System’ we have added six factors that are used to assign women to the correct **antenatal** pathway.[111]

Details of the six factors are listed in Table 5.2.

[111] The delivery and post-natal pathway include the same factors as the 2014/15 national tariff.

Table 5.2: Changes to the factors for the 2015/16 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

Once these currency changes are in place, we expect there will be a higher proportion of women in the intermediate and intensive categories for the antenatal pathway. Our projection of the proportions is:

- standard: 64.0% (down from 65.3%)
- intermediate: 28.2% (up from 27.4%)
- intensive: 7.8% (up from 7.3%).

As a result of these changed proportions, the price for each category of antenatal pathway is slightly lower than would otherwise be the case when using the same cost base.

5.4.3 Calculation of updated maternity pathway prices

The maternity pathway group together a range of services into a single payment, and therefore require a separate methodology to the rest of our main pricing model. Although the calculation steps are slightly different, we use many of the same sources of data that are used in our main national price models (eg 2011/12 reference costs data).

For 2015/16, we are using a comparatively simple method to set maternity pathway prices. For the antenatal and postnatal pathways, our method maintains the **relative** price levels between the standard, intermediate, and intensive categories, in each of the antenatal and postnatal pathways, that are in place for 2014/15. We did not have enough new evidence about the relative costs of each category to make any changes to the relative prices.

In the case of the delivery pathway, we were able to calculate new prices, without reference to the 2014/15 relativities. This is because the delivery pathway does not rely on additional case mix information aside from that derived from the HRGs.

Using the methods described above, we calculated the **level** of pathway prices that would give providers the opportunity to recover the efficient costs of service. This means that we have used 2011/12 reference costs data, adjusted for cost uplifts and efficiency. This adjustment is consistent with the approach that we had taken with other national prices.

The details of our maternity pathway price calculation are available in Annex 5i.

5.4.4 New best practice tariff: heart failure

In subsection 4.3.7, we explained that we have introduced a new best practice tariff (BPT) for heart failure services in 2015/16. Payment of this BPT is made only to trusts that both:

- submit at least 70% of their clinical data to the National Heart Failure Audit
- ensure at least 60% of heart failure patients receive specialist input.

The BPT comprises of two prices per HRG (EB03H and EB03I, heart failure or shock with and without complications and comorbidities). Commissioners will pay a base price set at 90% of the BPT price where providers provide the service but do not meet the required criteria.

We propose to set the base price for this BPT 5% higher than the current average cost level (ie the APC modelled price).

5.4.5 Amendments to best practice tariffs

As described in Section 4.3.7 of the ‘2015/16 National Tariff Payment System’ we are making amendments to four existing BPTs.

Similar to other national prices, we have used 2011/12 HES activity data and reference costs data to update BPT prices. The price setting methodology applied in the calculation of existing BPTs is consistent with the methodology applied in the 2014/15 National Tariff Payment System, aside from the BPTs documented below and in a small number of cases where prices have been rolled over from 2014/15.

Day-case procedures BPT

We are increasing the rate of day-case procedures used in the calculation for two procedures.

1. Operations to manage female incontinence:

   The BPT calculation assumes 60% of all procedures will take place in a day-case setting.

2. Tympanoplasty:

   The calculation assumes 65% of activity will take place in a day-case setting.

This assumption makes a difference to the price level for the services, as we are assuming a greater proportion of care will be delivered as day cases rather than as admitted patient cases. We follow the 2013/14 PbR methodology, whereby prices are calculated to over reimburse the costs of day case activity, while under reimbursing the costs of ordinary elective procedures. The tariffs for both settings are set so that the average provider will only break even if it performs in line with the best practice rates noted above. We assume, as a result, that overall costs will be lower, therefore a lower price is appropriate.

Outpatient procedures BPT

We are making amendments to the diagnostic hysteroscopy BPT, where the outpatient rate used for calculating price is increasing to 70%.

To incentivise a move to outpatient procedures, the prices for these procedures have been set higher than the day-case/elective price. For 2015/16, we have updated the methodology of calculating this BPT .

Endoscopy BPT

We are amending the BPT for endoscopy procedures from a two tier pricing structure to a three tier pricing structure.

The BPT still comprises of a single tariff price per each HRG. Endoscopy units achieving level one of Joint Advispory Group (JAG) accreditation will receive the full BPT price. Units achieving level 2 or 3 of JAG accreditation will receive a price calculated as 97.5% or 95% of the full BPT tariff price respectively.

Primary hip and knee replacement outcomes

In 2015/16 payment for these BPTs are made based on trusts meeting the following criteria:

- the provider not having an average health gain significantly below the national average
- the provider adhering to the following data submission standards:
    - a minimum patient-reported outcome measures (PROMS) participation rate of 50%
    - a minimum National Joint Registry (NJR) compliance rate of 85%
    - an NJR unknown consent rate below 15%.

As in 2014/15, the BPT comprises of a single price per HRG (HB12B, HB12C, HB21B and HB21C) with provision for commissioners to pay a price set at 90% of the BPT price where providers do not meet the required criteria. Whilst the criteria for trusts to receive BPT payments has been updated, the methodology to the calculate the BPT is consistent with the approach applied in the '2014/15 National Tariff Payment System'.

5.5 Cost uplifts

[*Please note that the following section outlines inputs into the pricing method from external sources, which form the basis for the individual cost uplifts (ie estimates or other figures from the Department of Health, HM Treasury or NHS England). The proposed uplifts set out below use current available estimates or figures – these would be updated, if necessary, before the final tariff is published. The relevant figures are set out in square brackets below.*]

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

Therefore, for those changes in costs over which providers have little control it is appropriate to make corresponding changes to the prices. In other regulated sectors, cost uplifts are sometimes covered by a single factor, usually the retail price index (RPI). But for the '2015/16 National Tariff Payment System', we have used an approach consistent with that used by the DH under the PbR system to calculate 2013/14 national prices, which is more tailored to cost pressures facing the NHS. We also used this approach when setting 2014/15 national prices.

As outlined in Section 5.3.2, our starting point for setting 2015/16 prices is the total cost base for 2014/15. Therefore, starting point prices would reflect 2014/15 cost levels. As such these prices must be updated to reflect costs that are expected to be incurred by providers in the 2015/16 tariff year. We do this through applying a set of 'cost uplifts', which reflect changes in input costs between 2014/15 and 2015/16. These are outlined below.

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

Our approach includes cost uplifts in six categories. These are:

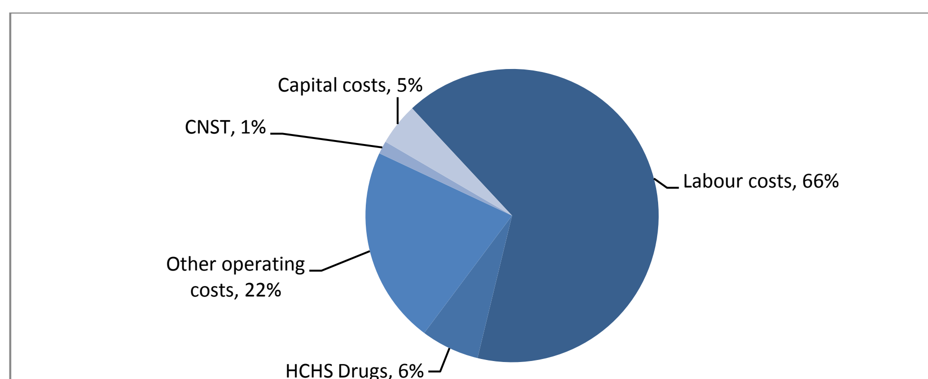
- labour costs
- drugs costs
- other operating costs
- changes in the cost of the CNST
- changes in capital costs (ie changes in costs associated with depreciation and Private Finance Initiative payments)[112]

[112] In line with the DH's past approach, we have included an estimate of how these payments will change in aggregate for 2015/16 as part of our cost uplifts.

- additional costs as a result of changes to NHS England's Mandate. We call these changes 'service development'. The service development figure will not be published until after November 2014 and an updated figure will be used in the national tariff document if available in time.

Proportional impact of cost pressures varies, as above costs make up different proportions of total expenditure. In setting the total cost uplift factor, each cost category therefore has to be assigned a weight. These weights are based on aggregate provider expenditure obtained from the DH's published 2013/14 financial accounts. Figure 5.3 below shows the weights applied to each cost category.[113]

Figure 5.3: Breakdown weights used in calculating the tariff cost uplift



Source: DH, with Monitor calculations.

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

5.5.1 Inflation in operating costs

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

- labour costs
- drugs costs
- other operating costs.

[113] See: 'Annual Report and Accounts 2013-14 ', table 2.2: Departmental Group Detail Expenditure

Pay

As shown in Figure 5.3 above, labour 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.

Pay-related inflation has three elements. These are:

- pay settlements, which is the increase in the unit cost of labour reflected in pay awards for the NHS
- 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 that providers pay to staff
- pensions, which takes account of changes to the cost of pension provision and results from a revaluation of required NHS pension contributions.

We have used the DH's central estimates for most of these components, since the DH maintains the most accurate and detailed records of labour costs in the NHS, and is directly involved in pay negotiations. However, for the pay drift estimate we have not used DH's central estimate but one of its scenario estimates as we found that this figure is more consistent with assumptions underpinning the national tariff.

For this year, we have not split the pay inflation estimate explicitly between the three elements. Current projection of the overall pay inflation rate is [figure subject to negotiation]% in 2015/16. This translates into a [figure subject to negotiation]% increase in national tariff prices.[114]

[114] *[While we have used current projections of the pay inflation, this figure will be updated in the final tariff.]*

Drugs

Drugs cost uplift recognises the expected increase in cost of tariff services through an increase in usage and/or cost of drugs. Although drugs costs are a relatively small component of total provider expenditure (approximately [6.4%]), they have historically grown faster than other costs. This can make drugs costs one of the larger cost uplift components in some years.

We have slightly modified our methodology to calculate the drugs uplift factor for 2015/16. Previously, the drug uplift factor was measured as the increase in total drugs' spend over a given year. This approach considered both the increase due to price and the increase due to activity. We calculate the drug cost uplift by considering only the increase due to price and removing 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 HRG volumes and therefore payments.

To reflect the expected increase in drugs costs, we have used the DH's estimate. This estimate is based on long-term trends and the DH's expectation of new drugs coming to market, and other drugs that will cease to be provided solely under patent in the coming 12 months. The DH has provided us with its best estimate of the increase in drugs unit costs for providers in 2015/16. This figure is [figure subject to negotiation], which translates into a [figure subject to negotiation] cost uplift once the weighting of the increase is taken into consideration.

Other operating costs

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 is from the Chancellor's Budget Statement of March 2014 (1.6%), which translates into a [0.35%] cost uplift once the weighting of the increase is taken into consideration].[115]

[115] *[While we have used March Statement as the current projection, we will update this value with the latest GDP deflator forecast when it is announced in the Chancellor's Autumn Statement.]*

5.5.2 Clinical Negligence Scheme for Trusts (CNST)

CNST is an indemnity scheme for clinical negligence claims. Providers make a contribution to the scheme to cover the legal and compensatory costs of clinical negligence.[116] 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.

Following the previous DH approach, we have allocated the increase in CNST costs to core HRG sub-chapters, to the maternity delivery tariff and 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 HRGs, the estimate of the CNST cost increase is different for each HRG sub-chapter and for the maternity delivery tariff. Each relevant HRG has received an uplift based on the change in CNST cost across specialties mapped to HRG sub-chapters. 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.[117]

CNST uplifts account for a [35%] increase in CNST costs. This reflects the average CNST contribution increase estimated by NHSLA, net of any non-tariff payments designed to compensate for CNST costs (taking into account outpatient and other services).

Table 5.3 below lists the percentage uplift that we have applied to each HRG sub-chapter to reflect the increase in CNST costs.

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

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

Table 5.3: CNST tariff impact by HRG sub-chapter

HRG sub-chapter	% uplift	HRG subchapter	% uplift	HRG sub-chapter	% uplift
AA	1.02	HD	0.67	PA	1.72
AB	0.67	HR	1.49	PB	0.00
BZ	1.03	JA	1.01	QZ	0.97
CZ	0.56	JC	0.90	RA	0.00
DZ	0.20	JD	0.49	RC	1.00
EA	0.38	KA	0.76	SA	0.48
EB	0.28	KB	0.28	SB	0.00
FZ	0.92	KC	0.24	SC	0.00
GA	1.18	LA	0.24	UZ	0.00
GB	0.53	LB	0.57	VA	1.16
GC	0.95	LD	0.00	WA	0.53
HA	1.20	MA	2.11	A&E	2.15
HB	1.41	MB	1.67	Maternity	11.09
HC	1.47	NZ	0.00		

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

The vast majority of the increases in CNST costs are allocated at HRG sub-chapter level, maternity tariff or A&E, but a small residual amount (about £24.6 million out of a total £1.4 billion CNST cost) is unallocated. This unallocated figure is re-distributed as a general uplift across all prices. We have calculated the uplift due to this pressure as [0.03 per cent] in 2015/16.[118]

[118] $uplift = \left(\frac{unallocated\ CNST\ cost}{(2014/15 total\ CNST\ costs + 2015/16 allocated\ CNST\ cost\ increase)}\right) \times CNST\ as\ proportion\ of\ total\ cost$

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

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

In previous years, the DH reflected changes in these capital costs when calculating cost uplifts, and we have adopted the same approach for the '2015/16 National Tariff Payment System'. Specifically, we have applied the DH's projection of changes in overall depreciation charges and PFI payments.

In aggregate, the DH projects PFI and depreciation to grow by [3.5%] in 2015/16, which translates to a [0.16%] uplift on tariff prices.

5.5.4 Service development

[As the final Mandate for 2015/16 is yet to be published, the service figure and the text below may be revised on publication of the '2015/16 National Tariff Payment System'. Monitor and NHS England have agreed a process to ensure that the final Service Development figure is transparent. We will therefore engage with the sector on the proposed figure, changes to it as a result of any new policies, as well as the way that the service development uplift ***may*** *be applied across the sector. We will do this before finalising the 2015/16 figure in the National Tariff Payment System.]*

The service development uplift factor reflects the additional costs to providers of major initiatives that are in NHS England's Mandate.[119]

[For 2015/16, NHS England has not identified any new policies that will incur additional costs for providers. We have therefore set the service development uplift at 0%.]

5.5.5 Summary of data for cost uplifts

Given the above, we estimate the overall inflation figure for 2015/16 national prices is [1.93%] as shown in Table 5.4 below.

[119] 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.

Table 5.4: Cost uplift calculation

Uplift factors	15/16 Weighted average estimate (uplift x weighting)
Pay and drugs costs	[1.40%]
Other operating costs	[0.35%]
Unallocated CNST	[0.03%]
Capital costs	[0.16%]
Total	**[1.93%]**

Notes: Unallocated CNST refers to individual HRG sub-chapters. Numbers may not add up exactly due to rounding.

5.6 The efficiency factor

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 2015/16, compared with 2014/15.

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 2015/16. It was developed, with input from stakeholders, over the course of the year, recognising current data limitations

The framework was consulted on as part of the 'National prices methodology discussion paper' and the TED, published earlier in 2014. It offers greater predictability and clarity for providers and commissioners. In turn, that should allow for better planning and, ultimately, better outcomes for patients.

The framework we have developed consists of four elements:

a. producing an initial range of the efficiency opportunity

b. listening to stakeholders

c. assessing the impact

d. deciding based on our statutory objectives.

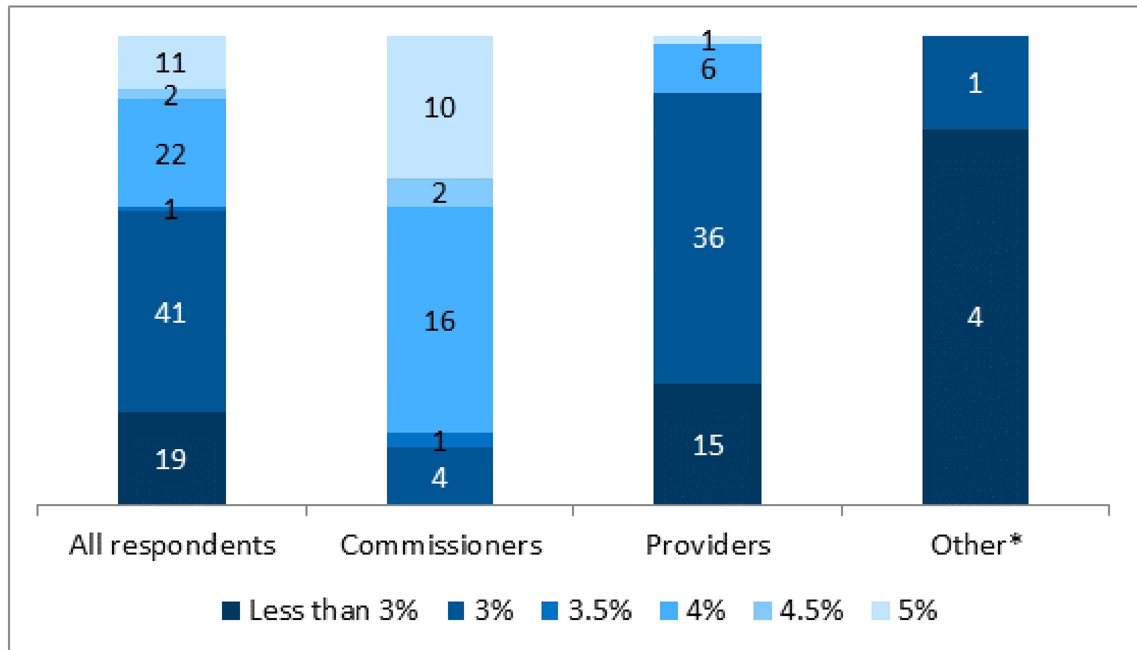
Monitor and NHS England have previously set out planning assumptions of an efficiency factor of 4.5% – ie that, all other things being equal, costs, and therefore prices, will be 4.5% lower in 2015/16 than they were in 2014/15.[120]

In the TED, we engaged the sector on an initial efficiency factor range of 3–5% and stated our expectation to set the final efficiency factor within that range. In setting this range, we noted that the financial challenges the sector is expected to face in 2015/16 are significant and that as a result, we expected that extraordinary effort will be required to achieve efficiency improvements, across all parts of the sector, to outpace historical trends.

A key part of the TED was to seek sector feedbak on the efficiency factor range. Stakeholders offered a broad range of views as illustrated in Figure 5.4. Providers were fairly uniform in their view that the efficiency factor should be at the lower end of the range. In contrast, commissioners were split between those who supported an efficiency factor at the upper end of the range, a smaller proportion who supported an efficiency factor at the lower end of the range, with the majority considering the middle of the range, 4%, to be appropriate.

[120] See Monitor's 'Guidance for the Annual Planning Review 2014/15', www.gov.uk/government/uploads/system/uploads/attachment_data/file/283273/GuidanceAnnualPlanningReview2014-15Revised.pdf

Figure 5.4 Stakeholder feedback to the proposed efficiency factor



* 'Other' refers to individual clinicians and suppliers of drugs and devices.

Decision

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[121] to provide an evidence base for our decision. We interpreted this evidence as revealing that, based on historical performance, the sector can achieve a maximum of 4% in an average year.

This assumes that, as the system is reconfigured, in addition to usual annual sector-wide savings gained from technological advances and service delivery optimisation, improvements made by less-efficient providers towards practices of more-efficient comparable providers (referred to as 'catch-up') will be at the higher end of the possible range.

[121] 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

Setting an efficiency factor at the top of the possible range tasks providers with answering the financial challenges of 2015/16 through an extraordinary effort. This challenge is reinforced by commissioners who generally supported an efficiency factor set around 4% or higher, recognising the need to ensure patients have access to the services they need, and that such access operates fairly, while making the best use of the limited resources available.

On the other hand, we also considered recent performance by providers that suggests that achieved efficiency savings may be decreasing. Efficiency savings achieved by foundation trusts, as measured by achieved cost improvement programmes (CIPs), over the previous four years ranged between 3% and 4%. We note, however, that in the last two years performance was towards the bottom of this range.

Further, providers strongly felt that efficiency saving of 4% or higher is unachievable in 2015/16 and would threaten provider viability. Therefore providers felt that a lower efficiency factor should be set.

Ultimately, it is our judgment to depart from the views expressed in our forward planning guidance, and that an **efficiency factor of 3.8%** is appropriate for national prices in 2015/16. In accordance with the local pricing rules in Section 7, commissioners and providers should have regard to this efficiency factor when setting local prices (see Section 7).

Although this is a lower efficiency factor than in recent years, we consider it to be challenging but also achievable. That the factor is challenging is supported by our impact assessment that reveals impacts on expected provider deficits if the efficiency target is not met.

This efficiency factor reinforces the need for providers to work hard in continuing to strive to deliver high quality care at lower cost. However, we believe that decreasing the efficiency factor from that assumed in forward planning guidance, and even from the factor set out in the 2014/15 national tariff, reduces the risk of efficiency targets not being met. Subsequently, the likelihood of the efficiency factor putting pressure on provider finances and the risk of adverse impact on the quality or safety of services are also reduced. We also considered that the financial pressure could be further eased through other actions by providers and commissioners, some of which were previously described as leakage.

Given the above, we concluded that this efficiency factor strikes the right risk-benefit balance in delivering best value for patients. While this efficiency factor is appropriate on a standalone basis we also note that it is important to see it as a coherent component of the ‘2015/16 National Tariff Payment System’ package, which is focussed on allocating those demands on commissioners and providers that they are best placed to meet.

5.7 Overall price adjustments

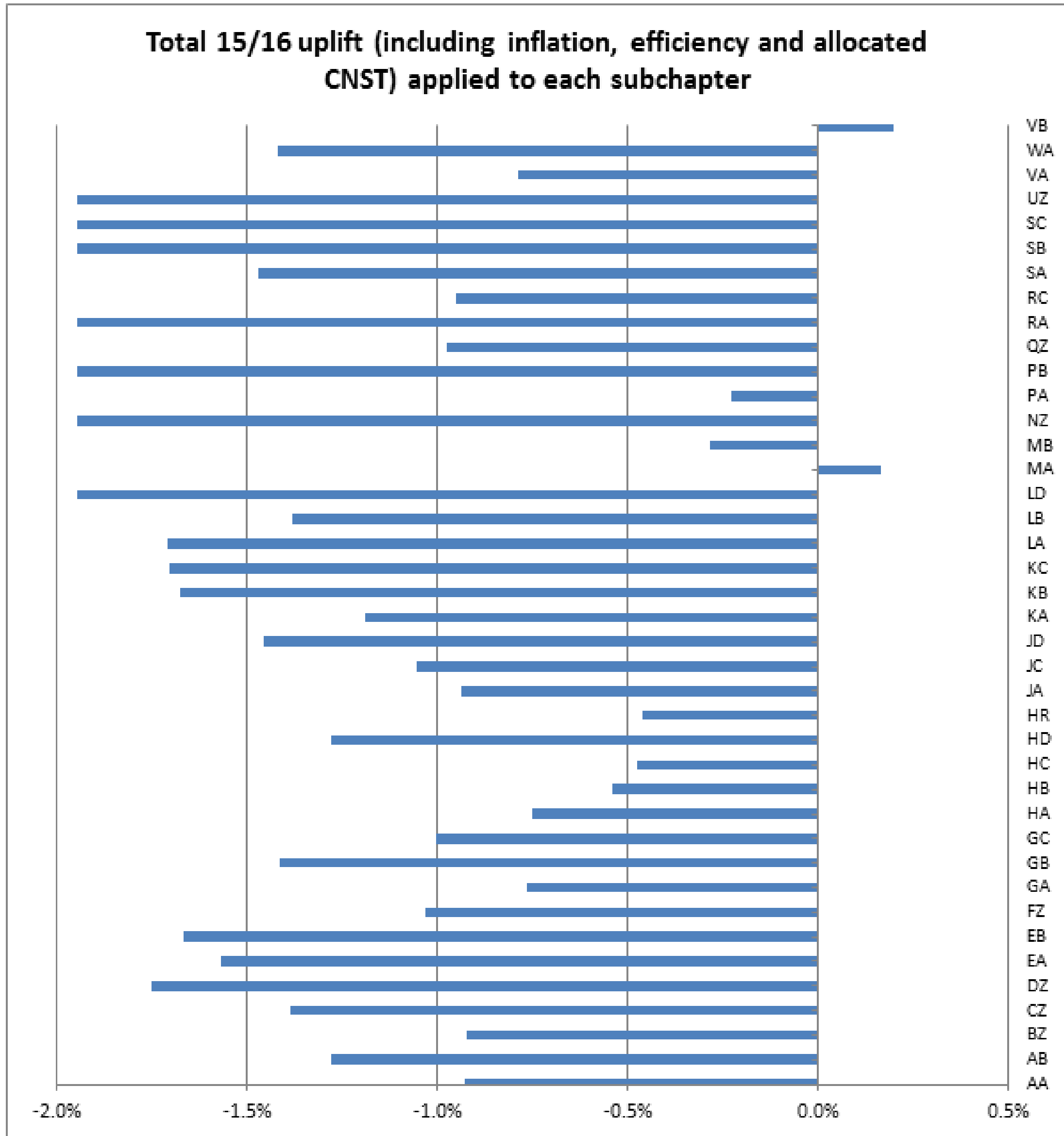
On **average**, and not taking account of the CNST costs that we allocate to specific groups of HRGs, national prices for 2015/16 are around [1.9%] lower than their corresponding 2014/15 prices. This reflects both:

- cost uplifts which increase prices on average by around [1.9%], offset by:
- the efficiency requirement, which reduces prices by 3.8%.

A further, and final, adjustment is made at a HRG sub-chapter level to reflect the impact of the allocated costs of CNST. This has the impact of increasing national prices. After accounting for allocated costs of CNST, national prices will be, on average, [0.8%] lower than in 2014/15.

Figure 5.5 below shows the national price change for each HRG sub-chapter from 2014/15 prices, after all adjustments (ie the general cost uplift including service development, the efficiency requirement, and the sub-chapter specific adjustments for CNST).

Figure 5.5: Total price change by sub-chapter



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6 National variations to national prices

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

We refer to these nationally determined adjustments as 'national variations' to national prices. We refer to the price, after application of national variations, as the 'nationally determined price'. Specifically, each national variation aims to achieve one of the following:

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

This section sets out the national variations specified in the '2015/16 National Tariff Payment System', under section 116(4)(a) of the Health and Social Care Act 2012 ('the 2012 Act'), with one exception: an additional national variation for acute prescribed specialised services is set out in Section 8.

The national variations for 2015/16 set out in this section are largely unchanged from 2014/15. However this is with the exception of 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 are removing these variations on the basis that the sector has had sufficient time to adapt to the new payment arrangements.

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

- National variations only apply to services with a national price.
- 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 7.2).

- In the case of an application or agreement for a local modification (see Section 7.3), 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).
- Where a new service is commissioned that does not have a national price, rules for local price-setting apply (see Section 7.4).

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

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

[The list of transactions will be finalised and updated for publication of the '2015/16 National Tariff Payment System' after the consultation period.]

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.

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).

Further information on the calculation and application of the MFF is provided in the supporting guidance document 'A guide to the Market Forces Factor'.

The 2014/15 MFF indices remain unchanged for 2015/16, except in cases where organisations are merging or are undergoing some other organisational restructuring (such as dissolution) during 2014/15. The 2015/16 MFF index values for each NHS provider can be found in Annex 6a.

Organisations merging or undergoing other organisational restructuring after 31 March 2015 will not have a new MFF set in-year; any MFF change will be calculated and confirmed by Monitor and will apply from 1 April 2016. 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.

6.2 Variations to reflect patient complexity – top-up payments

National prices in this national tariff are calculated on the basis of average costs. They 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.

Specialised service top-ups have been part of the payment system since 2005/06, although the current list of qualifying specialised services, and the design and calculation of specialised top-ups for these services, is informed by work undertaken in 2011 by the Centre for Health Economics (CHE) at the University of York.[122] The Department of Health has published an explanatory note to accompany the CHE publication.[123]

The levels and coverage of top-up payments for 2015/16 are the same as for 2014/15. These are set out in Table 6.1 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.

[122] For example, see the following publications by the CHE: Estimating the costs of specialised care and Estimating the Costs of Specialised Care: Updated Analysis Using Data for 2009/10.

[123] http://www.nspcc.org.uk/preventing-abuse/child-protection-system/children-in-care/

Table 6.1: Specialised service top-ups

	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

Annex 6b lists those providers eligible for specialised service top-ups. This list has not changed from that in the 2014/15 national tariff. Annex 6b also lists the top-up trigger codes.

In light of the recent changes to specialised commissioning arrangements (including a new list of prescribed services), and the possibility of adopting the HRG 4+ currency design in future years, we are working with the CHE to review specialised services top-ups. We are investigating the extent to which there are additional costs for patients who receive specialised care that are not currently reflected in national prices, under different HRG designs and under different definitions of specialised services. We have also established a sector stakeholder group with representation from a range of commissioners and providers to provide peer review of the CHE work. Results from the first phase of this project have been published by CHE.[124] We anticipate this work will be completed in early 2015 and that the final results will be available to inform the national tariff arrangements for 2016/17.

6.3 Variations to help prevent avoidable hospital stays

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

- the marginal rate emergency rule, which is amended for 2015/16
- the reimbursement arrangements for emergency readmissions within 30 days.

[124] For example, see: 'The Costs of specialised care' by the CHE.

As part of the development of the proposals for the '2014/15 National Tariff Payment System', NHS England and Monitor jointly reviewed historical evidence relating to emergency care and the marginal rate rule.[125] We found that the rule has gone some way to achieving its aims in that the growth rate of emergency admissions has slowed. We also received qualitative feedback suggesting that in some cases the rule has encouraged the more co-ordinated management of demand for emergency care and of discharges back into the community.

Over the past year, we started a full review of all existing payment arrangements for urgent and emergency care as part Sir Bruce Keogh's wider review of this area.[126] Alongside the '2015/16 National Tariff Payment System' we are publishing a preliminary design for a new payment arrangement for the entire urgent and emergency care pathway, which we are encouraging interested local areas to consider (see Section 7.5 on local payment examples).

This design enables the quality and outcomes of care delivered to be incorporated more fully into the payment design. It also enables individual providers to share in the financial effects of their actions on the care pathway as a whole. We expect the sector to make rapid progress towards adopting this and other innovative payment arrangements, which, in time, may mean existing marginal rate and emergency readmission rules are no longer required. In the meantime, we retain both variations in the 2015/16 national tariff and discuss each in turn below.

6.3.1 Marginal rate emergency rule

The marginal rate emergency rule was introduced in 2010/11 in response to a growth in emergency admissions in England that could not be explained by population growth and A&E attendance growth alone.[127] This growth in emergency admissions was made up primarily of emergency spells lasting less than 48 hours.

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

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

[125] See: NHS England and Monitor's joint review of the marginal rate rule.

[126] Earlier in the year we published 'Reimbursement of urgent and emergency care: discussion document on options for reform'.

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

The marginal rate rule sets a baseline monetary value (specified in GBP) for emergency admissions at a provider.[128] A provider is then paid a percentage of the national price for any increases in the value of emergency admissions above this baseline. Overall, commissioners must set aside sufficient budget to pay for 100% of emergency admissions. Commissioners are then required to spend the retained percentage on managing the demand for emergency care.

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:

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

The rule for 2015/16 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 50%, not 30%. This change recognises that efforts to contain non-elective admissions growth require partnership working from providers and commissioners and, as such, financial risk should be shared more equitably. The 2014/15 changes to baseline setting and reinvestment transparency are discussed, in turn, below.

Setting and adjusting the baseline

A provider's total baseline value must be assessed as the value of all emergency admissions at the provider in 2008/09 according to current 2015/16 national tariff prices.[129] A contract baseline value must be calculated for each contractual relationship.

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[128] 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).

[129] 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 best practice tariffs (with the exception of the best practice tariff that promotes same-day emergency care), A&E attendances, outpatient appointments, and contracts with commissioners falling within responsibility of devolved administrations.

We recognise that changes to HRGs since 2008/09 and the introduction of best practice tariffs (BPTs)[130] 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.

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 2015/16. Examples of relevant changes to consider include:

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

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 2015/16.

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

When assessing supply and demand for emergency admissions, commissioners should consider the factors set out in Table 6.2.

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

Table 6.2: Examples of where adjustments to baseline values may be required

Driver of change	Reason for change	Adjustment necessary?
Change in demand for admissions at a provider	Movement of demand between acute providers, resulting in altered market shares	Yes, if material and off-setting between providers
	Movement of demand between out-of-hospital care and acute care, or between secondary and tertiary providers	Yes, where it reflects a change in commissioning patterns[131]
	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[132]	No, unless this reflects a change in commissioning patterns
	Changes in the emergency services commissioned by CCGs (eg designation as trauma centre or hyperacute stroke unit)	Yes, if material
	Changes in the method for coding or counting emergency admissions	Yes, recalculate 2008/09 activity according to new method

When calculating baseline values, both increases and decreases in the value of activity should be considered equally according to the criteria in Table 6.2.

[131] 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).

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

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.

The agreed baseline value (specified in GBP) must be explicitly stated in 2015/16 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.

Acute providers or other parties in the local health economy should raise any concerns about baseline agreements with NHS England, through its area teams. Where local consensus cannot be reached, the area teams 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 area team is the commissioner, the NHS England regional team will provide mediation. In all cases, Monitor must be notified where concerns have been raised, and whether (and how) plans were changed as a result; this enables us to keep the operation of the rule under review.

Investing the retained funds

The 50% of the value of emergency admissions above a provider's baseline that is retained by commissioners must be spent on managing the demand for admitted emergency care. To comply with the variation, these investment decisions must be:

- properly prepared, with plans that are:
  - based on clear evidence that they can relieve pressure on emergency care
  - co-ordinated with other commissioning decisions on demand management
  - developed through constructive engagement and with input from system resilience groups.
- communicated to all relevant stakeholders, with plans:
  - published on their website
  - sent to the chief executives of relevant affected acute providers, and shared with Monitor, NHS England, and where relevant, the NHS Trust Development Authority

  - subject to oversight by NHS England, through its area teams.

- reviewed for effectiveness.

We discuss each requirement in turn.

Preparation of demand management plans

Commissioners should invest the retained funds, on the basis of clear evidence,[133] at the point in the system where investment will have greatest effect locally. As well as funding initiatives to reduce the number of emergency admissions,[134] this investment may also aim to improve a patient's recovery through earlier discharge, enhanced community-based rehabilitation and reablement to prevent inappropriate readmissions.

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

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

Commissioners must therefore prepare plans for managing demand early in the year. In doing so they should obtain input from their local system resilience group, in consultation with NHS England area or regional teams, and from all relevant providers and advisory groups (eg stroke networks).

Acute providers or other parties in the local health economy should raise any concerns about the investment plans with NHS England, through its area teams. Where local consensus cannot be reached, NHS England, through its area teams, will provide mediation, in the context of its CCG assurance role, to ensure CCG plans are consistent with this guidance. Where necessary, Monitor and NHS England will consider enforcing the rules set out in this guidance through their enforcement powers. Where the area team is the commissioner, the NHS England regional team will mediate. In all cases, Monitor must be notified where concerns

[133] This includes, for example: Interventions to reduce unplanned hospital admission: a series of systematic reviews, by ECIST; Urgent and emergency care – A review for NHS South of England, by the King's Fund; and NHS England: Improving A&E performance.

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

have been raised, and whether (and how) plans were changed as a result to enable us to keep the operation of the rule under review.

Communication of demand management plans

Under these requirements, commissioners must publish before the start of the financial year, on their website, details of their plans for investment of the retained funds. CCGs must also send these details to the relevant acute providers' chief executives. Monitor and NHS England should also be sent a copy.[135]

The communication of the plans should include:

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

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

Review of demand management implementation

Once agreed, the implementation of demand management investment initiatives will form part of the commissioner's quarterly assurance process.[136]

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

Application of the rule

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

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

[136] See the CCG Assurance Framework 2013/14

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[137] are not subject to the marginal rate rule, provided that the overall value of emergency admissions at the provider has decreased relative to their overall baseline value across all of their contracts.

The marginal rate should be applied to the value of a provider's emergency admissions after 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.

The marginal rate does not apply to:

- 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[138]
- A&E attendances
- outpatient appointments
- contracts with commissioners falling within responsibility of devolved administrations.

6.3.2 Emergency readmissions within 30 days

To provide the most suitable care for patients when they leave hospital, providers need to plan their discharge from admitted care. 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.

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

[138] 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.

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.

We are retaining this national variation for 2015/16. The rest of this section defines an emergency readmission for the purpose of the readmission rule, explains how savings made from applying the rule should be reinvested and sets out how the rule should be applied.

Definition of an emergency readmission

The definition of an emergency readmission is any readmission that:[139]

- happens up to 30 days from discharge from initial admission
- has an emergency admission method code[140]
- has a national price.

For 2015/16 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:

- any that do not have a national price
- maternity and childbirth[141]
- cancer, chemotherapy and radiotherapy[142]
- patients receiving renal dialysis
- patients readmitted after an organ transplant

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[139] 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.

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

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

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

- young children (under four years old at the time of readmission)
- patients who are readmitted having self-discharged against clinical advice[143]
- emergency transfers of an admitted patient from another provider, where the admission at the transferring provider was an initial admission[144]
- cross-border activity – where the initial admission or readmission is in Northern Ireland, Scotland or Wales.

Investing the savings

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

Application of the rule

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

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

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

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

Step 1 – clinical review

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.[145]

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.[146]

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.[147]

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

Step 2 – setting the threshold

The clinical 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.

As in 2014/15, providers and commissioners are not required to undertake a clinical review in 2015/16 where there continues to be local agreement on the readmissions threshold.

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

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

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

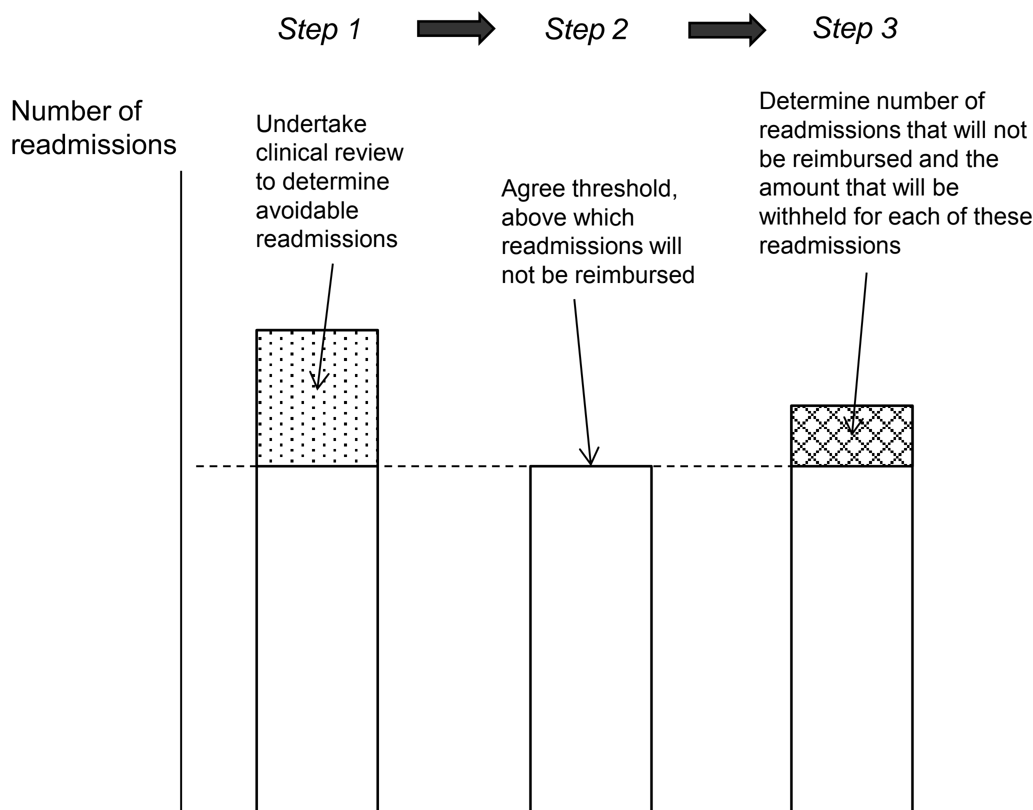
Step 3 – determining the amount not to be paid

The amount that will not be paid for any given readmission above the agreed threshold is the total price associated with the continuous inpatient readmission spell,[148] including any associated unbundled costs, such as critical care or high cost drugs.

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. [149]

The three steps for implementing the readmission rule are summarised in Figure 6.1. 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 6.1: Implementing the emergency readmissions rule



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

[149] The amount to be deducted from the first provider should be considered as equivalent to what would have been deducted had the patient been readmitted to the first provider, but with the second provider's MFF applied. This also applies where the readmission includes an emergency transfer.

6.4 Variations to support transition to new payment approaches

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 2015/16 we are removing three national variations that apply to the payment approaches for:

- the maternity pathway currency
- diagnostic imaging in outpatients
- chemotherapy delivery and external beam radiotherapy.

These national variations will no longer apply in 2015/16 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).

In 2015/16 we are retaining the national variation introduced in 2014/15 for the best practice tariff for primary hip and knee replacements.

6.4.1 Best practice tariff for primary hip and knee replacements

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.

In 2015/16 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:

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

Under this 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

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

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.

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.

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:

- 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.
- 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.
- 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.
- 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

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.

7. Locally determined prices

The previous sections of this document have considered healthcare services with nationally determined prices. However, in some cases prices for healthcare services may be determined locally. These are called locally determined prices,[150] and comprise local variations, local modifications and local prices.

This section has a number of annexes:

- Annex 7a, which gives more detail on the nationally specified currencies for acute services with no national price
- Annex 7b, which lists high cost drugs, devices and procedures
- Annex 7c, the mental health clustering booklet
- Annex 7d, which sets out details of the national currencies for ambulance and patient transport services.

It is also supported by the following documents:

- 'Enforcement of the national tariff for 2015/16'
- 'Guidance on locally determined prices for 2015/16'
- Local variations template and worked example (relevant to subsection 7.2)
- Local modifications template (relevant to subsection 7.3)
- Local prices template (relevant to subsection 7.4).

This section sets out certain principles that apply to all locally determined prices (subsection 7.1). It contains the rules for local variations (subsection 7.2) and the methods used by Monitor to consider local modification agreements and applications (subsection 7.3). In addition it contains rules on local prices (subsection 7.4), although this does not cover the rules for local pricing of acute prescribed specialised services, which are set out in Section 8. This section also contains guidance on the application of the rules and methods set out in this section.[151]

[150] Locally determined prices are also sometimes referred to as local payment arrangements.
[151] Commissioners have a duty to have regard to such guidance – 2012 Act, section 116(7).

Summary of locally determined prices

1. **Local variations** are adjustments to a national price or a currency for a nationally priced service, agreed by a commissioner and the provider(s) of that service. The intention is to allow commissioners and providers an opportunity to innovate in the design and provision of services for patients (see subsection 7.2).

   Under the Health and Social Care Act 2012 (the 2012 Act), local variations to a nationally determined price or currency must follow the rules set by NHS England and Monitor.[152]

2. **Local modifications** are adjustments to prices determined in accordance with the national tariff.[153] 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 subsection 7.3).[154] There are two types of local modifications:

   a. Agreements are where a provider and one or more commissioner agree a proposed increase to a nationally determined price for a specific service (see subsection 7.3.3).

   b. Applications are where a provider is unable to agree an increase to a nationally determined price with one or more commissioner and instead applies to Monitor for an increase to that price (see subsection 7.3.4).

Note that the method for determining local modifications is distinct from the rules relating to local variations. Local modifications must be approved or granted by Monitor to have effect.

3. **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 subsection 7.4 and Section 8).

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[152] Local variations are addressed by sections 116(2) and (3) of the 2012 Act.

[153] This primarily means national prices subject to national variations, but would also cover local prices where the national tariff rules determine the specific price to be paid.

[154] The legal framework for local modifications is set out in sections 116(1)(d), 124, 125 and 126 of the 2012 Act.

7.1 Principles for local variations, local modifications and local prices

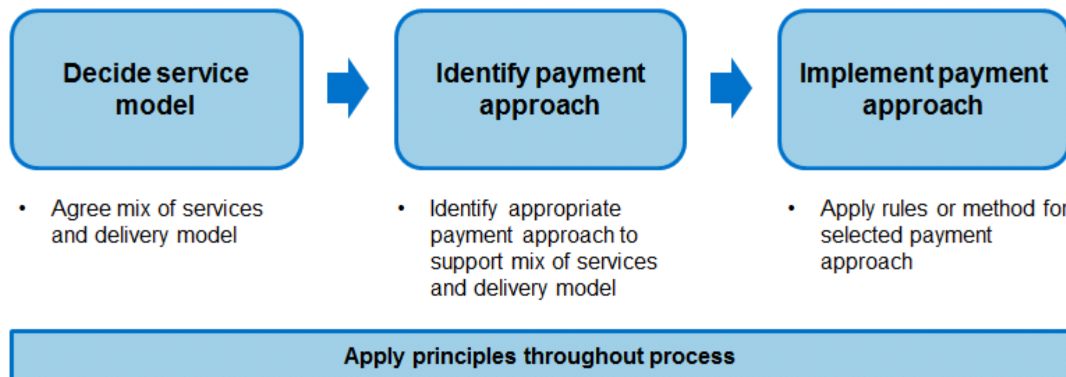
Commissioners and providers should apply the following principles when agreeing a local payment approach:

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

These principles are explained in more detail in subsections 7.1.1 to 7.1.3 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 NHS Regulations 2013,[155] and Monitor's provider licence.

The principles should be applied throughout the process of agreeing all local variations, local modifications or local prices. Figure 7.1 summarises the process.

Figure 7.1: Process for agreeing local variations, local modifications and local prices



[155] See the National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2013 (SI 2013/500).

7.1.1 Best interests of patients

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

- **quality** – how will the agreement maintain or improve the outcomes, patient experience and safety of healthcare today and in the future?
- **cost effectiveness** – how will the agreement make healthcare more cost effective, without reducing quality, to enable the most effective use of scarce resources for patients today and in the future?
- **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?
- **allocation of risk** – how will the agreement allocate the risks associated with changes to unit costs, patient volumes and quality in a way that protects the best interests of patients today and in the future?

7.1.2 Transparency

Local variations, modifications and prices should be transparent. 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:

- **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?
- **sharing best practice** – how will innovations in service delivery or payment approaches be shared in a way that spreads best practice?

7.1.3 Constructive engagement

Providers and commissioners must engage constructively with each other to decide on the mix of services, delivery model and payment approach that delivers the best value for patients in their local area. This process should involve clinicians, patient groups and other 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:

- **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?[156]
- **information sharing** – are there agreed polices for sharing relevant and accurate information in a timely and transparent way to facilitate effective and efficient decision-making?
- **involvement of clinicians and other stakeholders** – are clinicians and other stakeholders, such as patients or service users, involved in the decision-making process?
- **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?

Guidance on constructive engagement is set out in the supporting document 'Guidance on locally determined prices for 2015/16'.

[156] The NHS Standard Contract is used by commissioners of healthcare services (other than those commissioned under primary care contracts) and is adaptable for use for a broad range of services and delivery models, http://www.england.nhs.uk/nhs-standard-contract/

7.2 Local variations

Local variations are adjustments to a national price[157] 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:

- to offer innovative clinical treatments, deliver integrated care pathways or deliver care in new settings
- to bundle or unbundle existing national (healthcare resource group [HRG]) currencies to design a new service
- to design a new integrated service that combines service elements with national and local (HRG) currencies
- to support wide-scale reconfiguration and integration of primary, secondary and social care services
- to amend nationally specified currencies or prices to reflect significant differences in casemix compared with the national average
- to share contracting risks and gains between commissioners and providers to incentivise better care for patients.

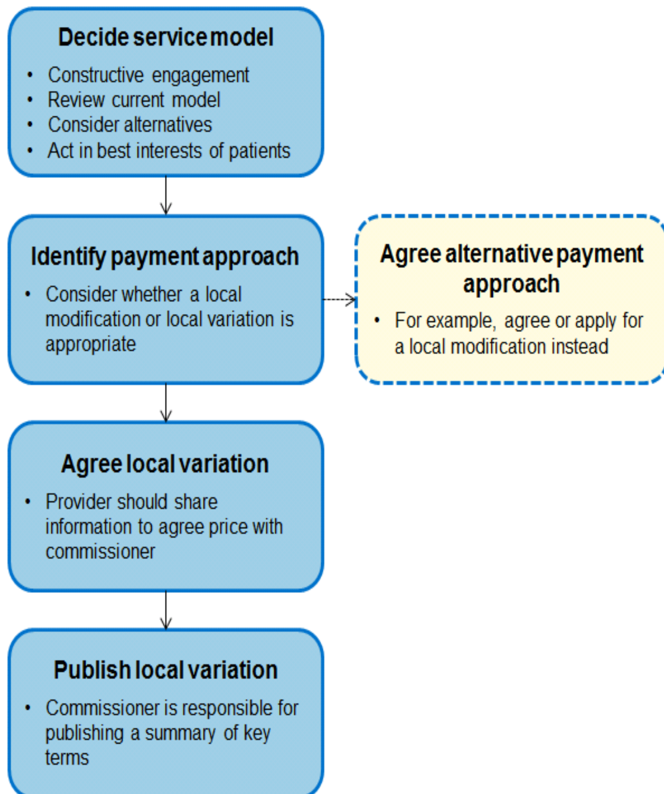
However, it is not appropriate for local variations to be used to introduce price competition. Further information on the use of local variations is set out in the supporting document 'Guidance on locally determined prices for 2015/16'.

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

7.2.1 Required process for agreeing local variations

The process for agreeing a local variation is summarised in Figure 7.2.

Figure 7.2: Process for agreeing local variations



7.2.2 Rules for local variations

For a local variation to be compliant with the national tariff, commissioners and providers must comply with the following rules.[158]

1. The commissioner and provider must apply the principles set out in subsection 7.1 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.[159]
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.[160]

[158] The rules in this section are made pursuant to the 2012 Act, section 116(2).
[159] The NHS Standard Contract is used by commissioners of healthcare services (other than those commissioned under primary care contracts) and is adaptable for use for a broad range of services and delivery models, http://www.england.nhs.uk/nhs-standard-contract/
[160] As required by the 2012 Act, section 116(3).

4.	The commissioner must also submit a written statement of the local variation to Monitor.

Guidance for complying with rules 2 to 4 is contained in subsection 7.2.3.

Monitor may take enforcement action in cases of non-compliance with these rules.[161] We may also request further information about any local variation from commissioners and providers. This information can be required under Monitor's statutory powers.[162]

7.2.3 Publication guidance for local variations

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

Under the 2012 Act, commissioners must maintain and publish a written statement of any local variation.[163] Commissioners should publish each statement within 30 days of agreeing the commissioning contract or, in the case of a variation agreed during the term of an existing contract, the date of the variation agreement. These statements (which can be combined for multiple services) must include details of previously agreed variations for the same services.[164] Commissioners must therefore update the statement if they agree changes to the variations covered by the statement.

The rules on local variations (see subsection 7.2.2) 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 on Monitor's website for information on how to submit a statement for publication.

NHS England requires commissioners to include their written statement of each local variation in Schedule 3 of their NHS Standard Contracts. The statement must be completed using the template specified by Monitor.

Requirements for completing a written statement

Monitor's requirements for a written statement on a local variation are set out in Monitor's template for local variations. In 2015/16 several new requirements have been introduced. These are:

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[161] See Monitor's Enforcement of the National Tariff for 2015/16.

[162] 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.

[163] 2012 Act, section 116(3).

[164] 2012 Act, section 116(3)(b).

1. For each local variation commissioners and providers are required to document how the service would have been delivered under the national price and currency and how will it differ under the local variation.

2. Commissioners and providers are also required to separately identify any non-recurrent costs of redesigning and restructuring services in the price agreed in the template where a local variation results in a higher agreed price than would otherwise be payable (for example, due to service redesign costs).

3. To ensure that all variations can be evaluated, commissioners and providers are required to identify the key performance indicators (KPIs) and metrics they will use to monitor contracts. This is part of governance arrangements to ensure that a local variation delivers its intended benefits (financial, qualitative, or otherwise). The KPIs and metrics should be specific, measurable, achievable, realistic, and time bound (SMART) and should form part of the commissioners' and providers' evidence that allows them to demonstrate their compliance with the national tariff.

Guidance on local variations is set out in the supporting document 'Guidance on locally determined prices for 2015/16'.

7.2.4 Additional guidance on local variations

How many commissioners and providers can agree a local variation?

Local variations can be agreed between one or more commissioner, including a lead commissioner, and one or more provider.

How many local variations can be covered by an agreement?

Commissioners and providers can enter into agreements that cover multiple variations to a number of related services. However, local variations only have effect for the services specified in the agreement, and for the parties to that agreement. Each variation applies to an individual service with a national price (that is, an individual HRG).

What is the duration of a local variation?

A local variation can be agreed for more than one year but must be reviewed annually to ensure it complies with the relevant national tariff.

Do local variations require approval from Monitor?

Local variations do not require approval from Monitor to have effect, but they must comply with the rules in the national tariff. Monitor has power to take enforcement action in any case where an agreement to vary the national price or currency does not comply with these rules.

7.2.5 Evaluation and sharing of best practice

We are interested in sharing learning from innovation in the design of service delivery models for the benefit of patients. To determine whether local variations and local prices have achieved their objectives, and to inform future decision-making, we recommend that commissioners and providers evaluate all locally determined prices.

In addition, NHS England and Monitor may evaluate local variations and local prices to identify the most successful and relevant for the future development of the payment system.

7.3 Local modifications

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.[165] There are two types of local modification:

1. **Agreements** are where a provider and one or more commissioner agree a proposed increase to a nationally determined price for a specific service (see subsection 7.3.3)
2. **Applications** are where a provider is unable to agree an increase to a nationally determined price with one or more commissioner and instead applies to Monitor to increase that price (see subsection 7.3.4)

Local modifications differ from local variations in that:

- **Local modifications** are subject to approval (in the case of local modification agreements) or grant (in the case of local modification applications) by Monitor.
- **Local variations** are not subject to approval or agreement by Monitor but they must comply with the rules outlined in subsection 7.2.2
- **Local modifications** can only be used to increase the price for an existing currency or set of currencies. For example, local modifications can be used to increase the prices paid to a provider where it faces unavoidable, structurally higher costs that make the provision of specific services uneconomic at the nationally determined price.[166]

[165] 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.

[166] 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.

- The method for determining **local modifications** is distinct from the rules relating to **local variations**.[167]

Under the 2012 Act, Monitor is required to publish in the national tariff its method for deciding whether to approve local modification agreements or grant local modification applications. This is set out in subsections 7.3.1 to 7.3.4.

Monitor's method provides that local modifications will be only be approved or granted if they meet specified conditions (see subsection 7.3.3 for local modification agreement conditions and subsection 7.3.4 for local modification application conditions). For both agreements and applications, Monitor must be satisfied that it would be uneconomic for the provider to provide one or more specific service without a local modification.[168] If Monitor is not satisfied, we will not approve a local modification agreement or grant a local modification application.

See Figure 7.3 for a summary of the principal differences between local modifications and local variations.

Figure 7.3: Principal differences between local modifications and local variations and the way they are funded by commissioners

	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

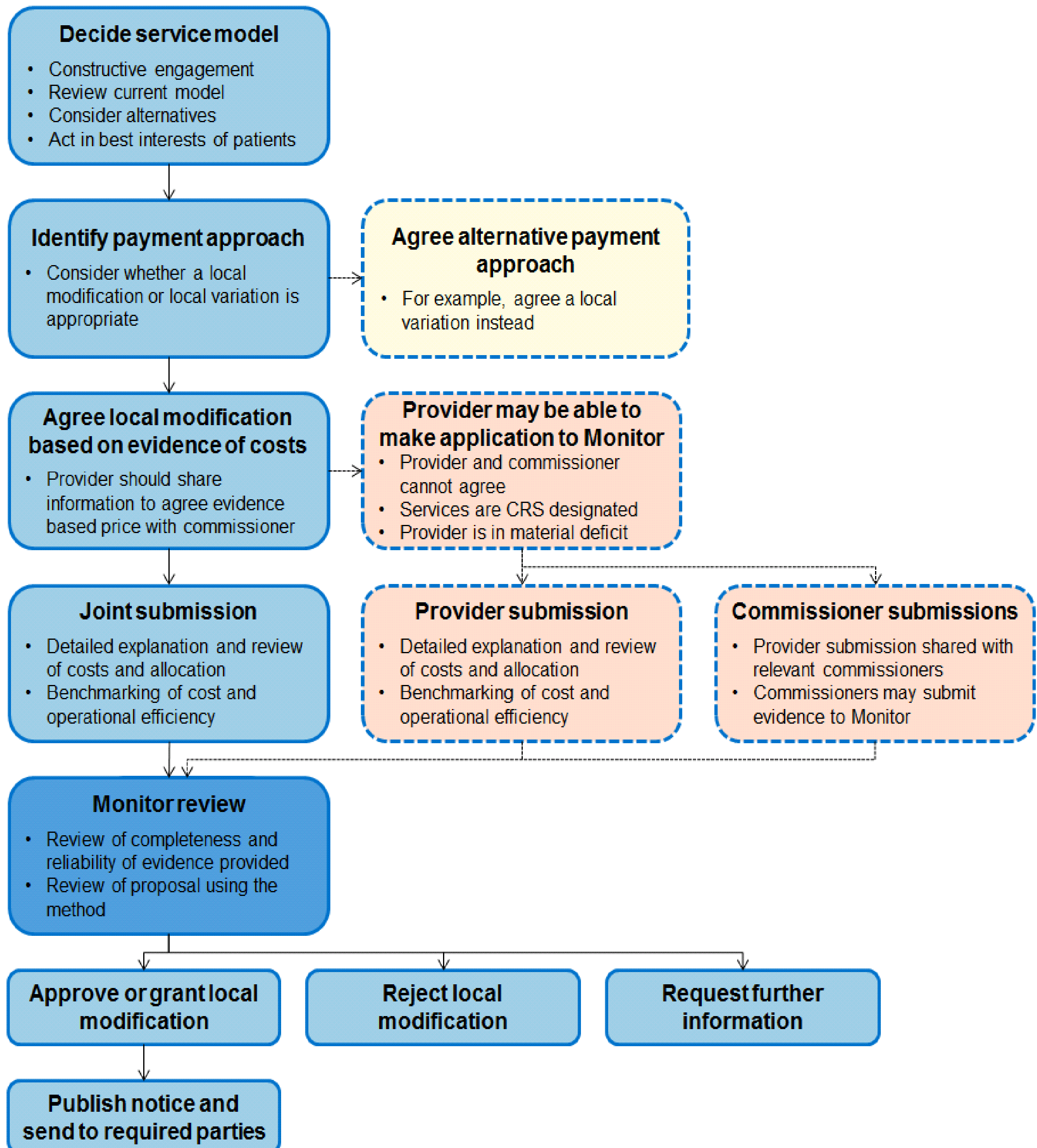
[167] Local variations are covered by sections 116(2) and (3) of the 2012 Act; local modifications are covered by sections 116(1)(d) and 124 to 126.

[168] 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.

7.3.1 Required process for agreeing local modifications

Monitor's method requires that commissioners and providers apply the principles set out in subsection 7.1, 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 7.4 summarises the required process for commissioners and providers.

Figure 7.4: Local modifications process for commissioners and providers



CRS = commissioner-requested services

7.3.2 Method for determining whether services are uneconomic

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:

1. Its average cost of providing each service is higher than nationally determined price.
2. Its average costs are higher than the nationally determined prices as a result of structural issues that are:
   - **specific** – the structurally higher costs should only apply to a particular provider or subset of providers and should not be nationally applicable
   - **identifiable** – the provider must be able to identify how the structural issues it faces affect the cost of the services
   - **non-controllable** – the higher costs should be beyond the direct control of the provider, either currently or in the past[169]
   - **not reasonably reflected elsewhere** – the costs should not be adjusted for elsewhere in the calculation of national prices, rules or variations.
3. It is reasonably efficient when measured against an appropriate group of comparable providers, given the structural issues it faces.[170]

[169] 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.

[170] 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.

Can other cost factors justify a local modification?

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 provider to have a detailed understanding of why its average costs exceed nationally determined prices.[171] It also requires analysis of whether the provider could reduce its costs while still delivering the quality of patient care required. 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 significant risk to the quality of care for patients.[172]

The provider (and, in the case of an agreement, the commissioner) should therefore provide sufficient evidence to enable Monitor to determine whether the service is uneconomic.[173] Where possible, Monitor expects providers to rely on existing information sources, including management and service line reporting. This should be supported by any additional analysis as required.

Monitor encourages providers and commissioners to submit evidence that applies to multiple services, in cases where more than one service is affected in the same way by a particular structural issue or issues. Further information on the type of evidence that should be provided is set out in the supporting document 'Guidance on locally determined prices for 2015/16'.

What supporting evidence does Monitor require to be submitted with a proposed local modification?

Monitor's requirements are set out in Monitor's template for local modifications[174]. For 2015/16 a new requirement has been introduced. Providers and commissioners should identify how they plan to address their structural issues in the medium term through strategic commissioning plans and provider business plans. Further, Monitor intends to share this information with the sector as part of our exercise to identify good practice unless a provider requests otherwise because of commercial confidentiality.

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[171] 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'. We expect providers and commissioners to have regard to this guidance when preparing supporting evidence for local modifications.

[172] For example, a hospital may be able to reduce the costs of providing services by improving the quality of its management or implementing cost improvement programmes (CIPs). It could also be possible to provide the services required using an alternative service delivery model.

[173] 2012 Act, sections 124(4) and 125(2), require that an agreement or application submitted to Monitor must be supported by such evidence as Monitor may require.

[174] The local modifications template is published as a supporting document to the '2015/16 National Tariff Payment System'.

7.3.3 Conditions for local modification agreements

Under the 2012 Act and the method for local modification agreements, the following three conditions must be satisfied:

1. The agreement must specify the services that will be affected, the circumstances or areas in which the modification is to apply, the start date of the local modification and the expected volume of activity for the period of the proposed local modification (which must not exceed the period covered by the national tariff).[175]

2. The commissioner and provider must be able to demonstrate that it is uneconomic for the provider to provide the relevant NHS services, based on the criteria set out above

3. The commissioner and provider must be able to demonstrate that the proposed modification reflects a reasonably efficient cost, given the structural issues faced by the provider.

Local modification agreements are agreed between the commissioner and the provider of a service. If there is more than one commissioner of a service from a single provider, the agreement may involve more than one of those commissioners acting as lead commissioner. A local modification agreement has effect only for the services specified in the agreement, and for the commissioners and providers which were parties to that agreement (or on whose behalf the agreement was entered into).

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.

7.3.4 Conditions for local modification applications

Local modification applications can only be made when a provider has not reached an agreement on a local modification with its commissioner.[176] 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.[177]

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[175] 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.

[176] See the 2012 Act, section 125(1).

[177] Constructive engagement is also required by condition P5 of the Provider Licence, in cases where a provider believes that a local modification is required.

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 be updated to reflect the modification.[178] 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).

To comply with our method for local modification applications, the applicant provider must:

1. Specify the services affected by the proposed local modification, the circumstances or locations in which the proposed modification is to apply, and the expected volume of activity for each relevant commissioner for the current financial year.
2. Demonstrate that it has 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.[179]
3. Demonstrate that the services are commissioner-requested services (CRS)[180] or, in the case of NHS trusts or other providers who are not licensed, the provider cannot reasonably cease to provide the services. Aspiring NHS foundation trusts should agree CRS with their commissioners while undertaking action under Monitor's five-step process to support their application.[181]
4. Demonstrate that it has a deficit equal to or greater than 4% of revenues at an organisation level in the previous financial year (that is, 2014/15 for the 2015/16 national tariff). The reason for this requirement is to take into account cross-subsidies, where providers receive a price that is greater than cost for some services but less than cost for others

[178] 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.

[179] Constructive engagement is also required by condition P5 of the Provider Licence, in cases where a provider believes that a local modification is required.

[180] See: 'Guidance for commissioners on ensuring the continuity of healthcare services: Designating commissioner requested services and location specific services', www.gov.uk/government/publications/guidance-for-commissioners-ensuring-the-continuity-of-healthcare-services

[181] Further information is available online at 'NHS commissioners: designate commissioner requested services (CRS)'. www.gov.uk/nhs-commissioners-designate-commissioner-requested-services

5. Demonstrate that it is uneconomic for it to provide the services required by its commissioners for the purposes of the NHS at the nationally determined prices, based on the criteria set out in subsection 7.3.2.
6. Propose a modification to the nationally determined prices of the specified services and be able to demonstrate that the proposed modification reflects a reasonably efficient cost of providing the services, given the structural issues faced by the provider.

Monitor may in exceptional circumstances consider an application which does not meet condition (3) or (4).

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 2015/16'.

7.3.5 Guidance for local modifications

Submission of local modifications

Local modification agreements and applications that relate to the financial year 2015/16 should be submitted to Monitor by 30 September 2015. By that date, commissioners and providers should have completed their contract negotiations and settled any agreement on prices (or identified that despite constructive engagement agreement cannot be reached). Receiving submissions by 30 September 2015 will allow the benefit of sharing the lessons learned from the submissions to be disseminated in time for the 2016/17 contracting round.

Agreements or applications submitted after that date will be considered, but Monitor would like this to be the exception. If commissioners and providers are considering a late submission, or one near the deadline, they should contact Monitor to discuss.

Publication of local modifications

Promoting transparency is one of the three principles that apply to all local variations, modifications and prices. As required by the 2012 Act, Monitor is required to publish key information on all local modification agreements and applications that are approved.[182] Monitor will also publish key information on local modification agreements and applications that are rejected, unless the circumstances of the case make it inappropriate.

[182] 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).

The key information published will include:

- whether the local modification is an agreement or application
- the name and location of the provider and commissioner or commissioners covered by the local modification
- a list of the services affected and the changes to their prices as a result of the local modification, including the circumstances or services for which the modification applies (or would have applied)
- in the case of an approved agreement or granted application, the start date and duration of the local modification
- an explanation of the structural issues faced by the provider and why a local modification was proposed
- any other information that Monitor considers relevant.

Notifications of significant risk

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.[183] These bodies must then have regard to the notice from Monitor when deciding on the commissioning of NHS healthcare.

7.4 Local prices

For many NHS services there are no national prices. Some of these services have nationally specified currencies, but others do not. In both cases, commissioners and providers must work together to set prices for these services. The 2012 Act 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.[184] We have set both general rules and rules specific to particular services. There are two types of general rule:

[183] 2012 Act, section 126(1) to 126(3).
[184] 2012 Act, section 116(4)(b) and (12) and section 118(5)(b).

1. 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 subsection 7.4.1

2. 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 subsection 7.4.2.

In addition to the general rules, there are rules specific to particular services. These are set out and explained in subsections 7.4.3 to 7.4.7.

The rules set out in this section do not apply to acute specialised services commissioned by NHS England's area teams. The local price-setting rules for those services are set out in Section 8.

Guidance on records and information

Providers and commissioners should record how they arrived at a local price, to demonstrate adherence to the rules and principles in the national tariff. Providers and commissioners will be expected to supply this information to Monitor's pricing enforcement and compliance team on request, or as part of any compliance audit to provide assurance of adherence to the national tariff.

The information that we expect providers and commissioners to hold is the same information that they should be using to monitor their contracts as part of their internal controls and governance arrangements. There is no expectation that this proposal would require new information to be produced by providers and commissioners.

7.4.1 General rules for all services without a national price

The following rules apply when providers and commissioners set local prices for services without national prices.[185] The rules apply irrespective of whether or not there is a national currency specified for the service.

Rule 1: Providers and commissioners must apply the principles in Section 7.1 when agreeing prices for services without a national price.

Rule 2: Commissioners and providers should have regard to the national tariff efficiency and cost uplift factors for 2015/16 (as set out in Section 5 of this document) when setting local prices for services without a national price for 2015/16.

[185] The rules specified here do not however cover the setting of prices for acute specialised services commissioned by NHS England – the rules for those services are set out in Section 8.

The following paragraphs provide guidance as the application of rules 1 and 2.

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. When adjusting prices agreed in previous years commissioners and providers may agree to make price adjustments that differ from the adjustments for national prices where there are good reasons to do so. In addition, commissioners should ensure that local prices are in the best interests of patients and that they engage constructively when setting local prices, in accordance with rule 1 and the principles set out in subsection 7.1.

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.

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

Relevant factors may include, but are not restricted to:

- commissioners agreeing to fund service development improvements
- additional costs being incurred as part of service transformation
- taking account of historic efficiencies achieved (eg where there has been a comprehensive service redesign)
- accounting for the needs of the local population and local demand for service
- comparative information (eg benchmarking) about provider costs and opportunities for efficiency gains
- additional funding for specific purposes as it is made available (for example, in 2015/16 NHS England has made available additional funding to support improved access to early intervention care for psychosis).

7.4.2 General rules for services with a national currency but no national price

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

Services that have national currencies but no national price are:

- Working age and older people **mental health services**
- **Ambulance services**

- The following **acute services**
  - specialist rehabilitation (25 currencies based on patient complexity and provider/service type)
  - critical care – adult and neonatal (13 HRG-based currencies)
  - HIV adult outpatient services (three currencies based on patient type)
  - renal transplantation (nine HRG-based currencies)
  - positron emission tomography and computerised tomography (PET/CT) (HRG RA42Z – Nuclear Medicine category 8)
  - cochlear implants
  - complex therapeutic endoscopy
  - dialysis for acute kidney injury (HRGs LE01A, LE01B, LE02A, LE02B).

Rule 3

(a) Where there is a national currency specified for a service, the national currency must be used as the basis for local price setting for the services covered by those national currencies, unless an alternative payment approach is agreed in accordance with Rule 4 below.

(b) Where a national currency is used as the basis for local price setting, providers must submit details of the agreed unit prices for those services to Monitor using the standard templates provided by Monitor.

(c) The completed templates must be submitted to Monitor by 30 June 2015.

(d) The national currencies specified for the purposes of these rules are the currencies specified in Annex 7A (acute services), subsection 7.4.4 (mental health services) and subsection 7.4.5 (ambulance services).

The templates referred to in Rule 3 are published as supporting documents to the '2015/16 National Tariff Payment System'.

Rule 4

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

When doing so, providers and commissioners must adhere to the requirements (b), (c), (d) and (e) below, which are intended to mirror the requirements for agreeing a local variation for a service with a national price, set out in subsection 7.2.

(b) The agreement must be documented in the commissioning contract between the commissioner and provider which covers the service in question.

(c) The commissioner must maintain and publish a written statement of the agreement, using the template provided by Monitor, within 30 days of the relevant commissioning contract being signed or in the case of an agreement during the term of an existing contract, the date of the agreement.

(d) The commissioner must have regard to the guidance in subsection 7.2.3 when preparing and updating the written statement.

(e) The commissioner must submit the written statement to Monitor.

7.4.3 Acute services with no national price

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

In addition, there is a rule relating to high cost drugs, devices and listed procedures that are not reimbursed through national prices and whose price must be negotiated locally.

Please note that these rules do not apply to acute specialised services commissioned by NHS England. The rules relating to the setting of prices of those services are set out in Section 8 – this includes rules similar to those set out here, but also a new rule relating to the sharing of financial risk between NHS England and providers.

Acute services without national currencies

In addition to the general rules set out in subsection 7.4.1, the following rule applies:

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

Acute services with national currencies

The national currencies for acute services without national prices are set out in subsection 7.4.2. Currency specifications and the guidance around using these currencies are set out in Annex 7A.

Rule 6: Providers and commissioners must use the national currencies specified in Annex 7A as the basis for structuring payment for acute services covered by those national currencies, unless an alternative payment approach has been agreed in accordance with Rule 4 in subsection 7.4.2.

High cost drugs, devices and listed procedures

A number of high cost drugs, devices and listed procedures are not included in the national currencies and are therefore not reimbursed through national prices. Instead, they are subject to local pricing in accordance with the rule below. Annex 7b sets out the updated list of excluded drugs, devices and procedures for the '2015/16 National Tariff Payment System' that are subject to local prices.

Rule 7

(a) As high cost drugs, devices and listed procedures are not national currencies, Rules 3 and 4 in subsection 7.4.2, 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) As the price agreed should reflect the actual cost to the provider, the requirement to apply the national tariff efficiency and cost uplift factors detailed in Rule 2 in subsection 7.4.1 does not apply.

High cost drugs, devices and listed procedures are not included in the national prices for one or more of the following reasons:

- the intervention was new and not captured in national prices
- currencies had not yet been developed or adjusted for the use of the interventions
- the intervention was specialist and carried out by a small number of providers.

In all cases, their use tends to be disproportionately concentrated in a relatively small number of providers, rather than evenly spread across all providers providing services covered by the relevant currency. As a result of this and their high cost, a provider using one of these drugs, devices or procedures more frequently than 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.

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.[186] 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.[187]

7.4.4 Mental health services

In addition to the general rules for services set out in subsections 7.4.1 and 7.4.2, most adult mental health services are covered by three additional rules. Where mental health services are not covered by the adult cluster currencies, providers and commissioners must adhere to the general rules set out in subsection 7.4.1. For clarity, a list of services not captured by the adult cluster currencies can be found in our mental health guidance, 'Guidance on mental health currencies and payment'.

The use of care clusters to frame activity and a set of quality indicators (see Rules 8 and 9) has been mandated since April 2012. However, there is provision for commissioners and providers to use non-cluster-based payment approaches (see Rule 8a) where an alternative payment approach has been agreed in accordance with Rule 4. It is important to note that this does not remove the requirement for completion of the Mental Health Learning and Disabilities Data Set (MHLDDS) whether or not clusters have been used as the basis for payment (see Rules 9c and 10b). The distinction between requirements for payment and requirements for dataset submissions to the MHLDDS is important; payment can be based on a non-cluster approach but the dataset submission requirements apply in all cases.

Rules 8, 9 and 10 on adult mental health services (set out in full below) are virtually identical to Rules 8, 9 and 10 in the '2014/15 National Tariff Payment System'*.* They make provision for the delivery of transparent and accountable care. The only change is to update references to the 'Mental Health Minimum Data Set' to the new dataset, the MHLDDS. However, there are changes associated with this new dataset; further information can be found at the HSCIC's MHLDDS web page.[188]

Although there are no rule changes this year, where the rules are not applied we will, on a case-by-case basis and in accordance with Monitor's enforcement strategy, address non-compliance. This may include taking formal enforcement action.

[186] Further information about high-cost drugs, devices and procedures may be found online via the 'High cost drugs, devices and chemotherapy portals', www.gov.uk/nhs-commissioners-designate-commissioner-requested-services

[187] 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'.

[188] www.hscic.gov.uk/MHLDDS

Using the adult mental health cluster currencies

The adult mental health cluster currencies are summarised in Table 7.2

Table 7.2 Adult mental health clusters and associated maximum cluster review period

Cluster	Cluster label	Cluster review period (max)
0	Variance	6 months
1	Common mental health problems (low severity)	12 weeks
2	Common mental health problems	15 weeks
3	Non-psychotic (moderate severity)	6 months
4	Non-psychotic (severe)	6 months
5	Non-psychotic (very severe)	6 months
6	Non-psychotic disorders of overvalued ideas	6 months
7	Enduring non-psychotic disorders (high disability)	Annual
8	Non-psychotic chaotic and challenging disorders	Annual
10	First episode in psychosis	Annual
11	Ongoing recurrent psychosis (low symptoms)	Annual
12	Ongoing or recurrent psychosis (high disability)	Annual
13	Ongoing or recurrent psychosis (high symptom and disability)	Annual
14	Psychotic crisis	4 weeks
15	Severe psychotic depression	4 weeks
16	Dual diagnosis (substance abuse and mental illness)	6 months
17	Psychosis and affective disorder difficult to engage	6 months

18	Cognitive impairment (low need)	Annual
19	Cognitive impairment or dementia (moderate need)	6 months
20	Cognitive impairment or dementia (high need)	6 months
21	Cognitive impairment or dementia (high physical need or engagement)	6 months

Providers and commissioners must adhere to Rule 8 when using the adult mental health cluster currencies (care clusters).

Rule 8

(a) The 21 care clusters specified in Table 7.2 must be used as the currencies for agreeing local prices for the services covered by the clusters in 2015/16, unless an alternative payment approach has been agreed in accordance with Rule 4 in subsection 7.4.2.

(b) When using the care clusters, patients must be allocated to a cluster when:

i) initial assessment is completed (typically within two contacts, or two bed nights)

ii) there is a scheduled reassessment

iii) there is any reassessment after a significant change in need.

(c) Patient allocations must be regularly reviewed in line with the maximum cluster review periods, which are included in Table 7.2.

(d) Providers must use the mental health clustering tool (Annex 7C) to assign a care cluster classification to patients, and record and submit the cluster allocation to the HSCIC as part of the MHLDDS.

(e) Initial assessment must be treated as a standalone currency and paid for separately. At the end of an initial assessment, a patient's interaction with a provider may end or continue. If the patient's interaction with the provider continues, all ongoing assessments and reassessments form part of the allocated cluster.

(f) Cluster 0 must only be used when it is not possible to determine which cluster should be assigned to a patient at the end of the initial assessment

Local prices using care clusters should be calculated based on the maximum cluster review period. Full guidance on implementing the mental health care clusters can be found in our 'Guidance on mental health currencies and payment'.

Rule 8 makes clear that care clusters are the default local payment arrangement for adult mental health services. Payment arrangements for adult mental health services

not based on the core clusters should only be used in accordance with Rule 8 and Rule 4. Furthermore, our mental health guidance illustrates how we expect the three principles of local payment arrangements, set out in subsection 7.1.1, to be applied in practice to mental health services. In particular, we are aware that some non-cluster-based payment arrangements may not be operating in patient's best interests. Specifically, unaccountable block contracts have limited transparency regarding service provision, patient outcomes, quality, costs and value; nor do they facilitate patient choice or the wider roll-out of personal budgets.[189] We have revised guidance to support the sector in moving away from unaccountable block contracts, and towards the development of more transparent and tailored payment approaches.

It should also be noted that payment based on care clusters does not need to mean payment by activity. A range of or combinations of other payment approaches may be used, for example, payment linked to outcomes or to implementation of best practice pathways, or an increased focus on early treatment and prevention. We note here, as in Section 2, that in 2015/16 NHS England has made available additional funding to support improved access to early intervention care for psychosis. These payment approaches may support the integration of mental and physical health services. Information about support to the sector in this regard is set out in subsection 7.5. Commissioners and providers should undertake thoughtful analysis of local demand patterns by mental health users in determining the most suitable model.

Rule 9

(a) For each care cluster, quality indicators must be agreed between providers and commissioners. The recommended quality indicators can be found in section 4 of the 'Guidance on mental health currencies and payment'.

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

(c) Providers must complete the MHLDDS in all cases.

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

(e) Once agreed, the local prices for the care clusters must be submitted to Monitor by providers in line with the requirements of Rule 3 set out in subsection 7.4.2.

While enabling patient choice in mental healthcare will be undertaken at a local level,

[189] A personal health budget is 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. They are intended to enable people with long-term conditions and disabilities to have greater choice, flexibility and control over the healthcare and support they receive. More information about personal health budgets can be found on NHS England's website, www.personalhealthbudgets.england.nhs.uk/.

our mental health guidance provides information on how this can be supported by local price setting. Completion of the MHLDDS (including the cluster allocation) will allow activity and quality benchmarking of mental health providers. It will also facilitate any transfer of patients between providers for part of their pathway of care.

Agreements where care clusters are not used for payment

Rule 10

(a) Providers and commissioners of services covered by the care cluster currencies may agree prices without using the care clusters as the basis for payment. They must adhere to the requirements set out in Rule 4 in subsection 7.4.2.

(b) Providers must complete the MHLDDS in all cases, including the cluster allocation, whether or not they have used the care clusters as the basis for payment.

Where providers and commissioners agree prices that are not based on care cluster currencies, Rule 10 (b) requires that providers must still complete the MHLDDS. This contains the minimum requirements for quality and outcomes data. Since this requirement is narrower than Rule 9, commissioners and providers may wish to include additional quality and outcomes indicators in commissioning contracts.

7.4.5 Payment rules for ambulances and patient transport services

This section sets out the rules for local price setting for ambulance and patient transport services with and without national currencies, including the rules for providers and commissioners who do not wish to use the national currencies.

Ambulance services with national currencies

The national currencies for ambulance services introduced in April 2012 were developed and tested by providers of ambulance services and commissioners. The development of the currencies partly responds to the need for financial incentives to support integrated urgent care provision.

The four national currencies for ambulance services are:

1. Urgent and emergency care calls answered
2. Hear and treat or refer to other services
3. See and treat or refer to other services
4. See, treat and convey to hospital.

The details of these currencies – including how to determine what to include and exclude when applying them – are set out in full in Annex 7d. Any services not specified above are not subject to a national ambulance currency. In addition to the general rules in subsections 7.4.1 and 7.4.2, providers and commissioners must adhere to the requirements of Rule 11.

Rule 11

(a) Providers and commissioners must use the four national currencies specified above as the basis for structuring payment for ambulance services covered by those national currencies, unless an alternative payment approach has been agreed in accordance with Rule 4 in subsection 7.4.2.

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

(c) Once agreed, the local prices must be submitted to Monitor by providers in line with the requirements of Rule 3 set out in subsection 7.4.2.

Providers and commissioners may wish to agree prices without using the four ambulance currencies, for example, to support the redesign of urgent care services or to incentivise alternatives to conveyance to hospital such as hear or see and treat/refer. But they must comply with Rule 4 in subsection 7.4.2 when departing from the currencies.

Ambulance services without national currencies

When agreeing prices for ambulance services not covered by the national currencies, providers and commissioners must adhere to the general rules set out in subsection 7.4.1.

7.4.6 Primary care services

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

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

- 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)

- 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). [190]

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 subsection 7.4.1.

7.4.7 Community services

Payment for community health services must adhere to the general rules set out in subsection 7.4.1. This allows continued discretion at a local level to determine payment approaches that deliver quality care for patients on a sustainable basis.

Where providers and commissioners adopt alternative care pathway payment approaches that result in the bundling of services covered, at least in part, by national prices, the rules for local variations must be followed (see subsection 7.2).

7.5 Information on support to the sector: local payment examples

This section highlights that we will use the '2015/16 National Tariff Payment System' to support service innovation while we continue to evaluate potential long-term payment designs. We will produce and publish a series of payment design examples ('payment examples') as supporting guidance to the '2015/16 National Tariff Payment System' that support service improvement and reconfiguration. Providers and commissioners are encouraged to consider and adapt these payment approaches in 2015/16, as they see fit to meet their needs.

[190] These are arrangements made under the NHS Act 2006, sections 3 or 3A.

8. Acute prescribed specialised services

In the '2015/16 National Tariff Payment System' a new national variation and new local price-setting rules are being introduced for prescribed specialised services.[191] These changes are being introduced to promote value for patients by addressing the comparatively high annual growth rate in expenditure on these services. This section sets out:

- the rationale for policy change
- new payment arrangements, including a new national variation and a new local price-setting rule
- guidance on how to apply these rules and how they interact with other variations and rules described in Sections 6 and 7.

This section applies to **acute** prescribed specialised services, which incorporates the following Programmes of Care: Trauma; Women and Children; Cancer and Blood; Internal Medicine. It does not apply to prescribed specialised mental health services,[192] nor to services that are not prescribed such as those commissioned by clinical commissioning groups (CCGs).For those other services without national prices, commissioners and providers should continue to comply with the rules for local price-setting described in subsection 7.4.

In addition to the new rules, this section sets out the other rules that apply to price setting for acute prescribed specialised services without a national price. The rules are similar to those set out in subsection 7.4, but are set out here so that the local price-setting rules for these services are all contained in the same section of this national tariff.

8.1. Rationale for policy change

NHS England spends over £11 billion per annum on prescribed specialised services that relate to acute physical health care. Approximately 60% of these services are currently outside the scope of national prices, with prices determined locally through negotiations. About 20% of spend relates to high cost drugs, devices and procedures (see Annex 7b), where the price should reflect the actual cost incurred by the provider). The '2014/15 National Tariff Payment System' did not make any specific provision for how local prices for prescribed specialised services should be determined. Instead, the general and acute services local price-setting rules applied, which were designed to formalise and make transparent previous arrangements. These rules had a number of dimensions. Currencies were mandated for specified

[191] These are the specialised services prescribed by regulations under section 3B(1)(d) of the 2012 Act, as services which NHS England must commission, www.england.nhs.uk/2012/11/21/spec-services/

services (for example critical care) and stipulated the application of certain principles for local payment that should be adopted when agreeing prices. Commissioners and providers were also required to have regard to the national tariff efficiency and cost uplift factors where services already had a local price.

However, it is the view of NHS England and Monitor that the approach applied in 2014/15 to determining payments for acute prescribed specialised services may not have secured the best value healthcare delivery for patients. This is supported by:

- Analysis of reference costs and income data for acute providers which suggest that commissioner expenditure for services without national prices, many of which are specialised, has grown much faster over the past five years than payments for services with national prices
- The observation that while provider margins are falling in general, acute teaching and specialist hospitals' margins have declined less than those of other acute providers.[193]
- Findings that spend on prescribed specialised services substantially exceeded available financial resources in 2013/14 and faces considerable pressure in 2014/15 and 2015/16.

In summary, we found that the financial pressure on prescribed specialised services is due both to rising activity for locally and nationally priced services and to too little progress being made in the intended convergence of local currencies and prices.

In addition to these findings, NHS England's analysis of the long-term outlook suggests that expenditure will continue to increase under current conditions over the next five years and beyond, in the absence of action. The analysis identified activity as increasing not only due to demographic pressures, clinical prevalence and incidence of disease, but also because of changes in referrals, medical innovation and greater standardisation of care aligned to national clinical standards and specifications (eg regarding evidence-based access criteria for treatment). Monitor and NHS England share concern as to whether this rate of payment growth is in line with the best allocation of scarce NHS resources on behalf of patients.

In this context, NHS England and Monitor considered two policy options to promote value for patients from payment for acute services without national prices in the Tariff Engagement Document (TED). We considered introducing either: (i) more detailed guidance to inform contract negotiations between commissioners and providers or (ii) a new local price-setting rule. In response to sector feedback on the TED proposals, engagement with a range of stakeholders and our own analysis, we focused our policy development on acute prescribed specialised services. In

[193] For background see 'Into the Red? The State of the NHS' Finances', http://www.nuffieldtrust.org.uk/publications/red-state-nhs-finances

particular, we sought to understand better why efforts to contain growth in expenditure on specialised services without national prices (through standardising local currencies and encouraging convergence in price levels) appeared to have not been successful, and we found that NHS England teams frequently rolled forward most local prices for 2014/15, with only the national tariff efficiency factor and cost uplifts applied. We found that NHS England teams frequently lacked the transparent and reliable data needed to hold providers to account for the comparative efficiency and productivity of clinical services.

Work to speed up progress on the design and collection of standardised activity and cost data is essential. These data are a key building block if we are to develop national currencies and prices, which many stakeholders told us they wanted. NHS England's 'Commissioning Intentions 2015/16 for Prescribed Specialised Services'[194] indicates key actions NHS England intend to take to start to improve data and start service redesign; for example, through the transparent prioritisation of service developments, reviews of clinical thresholds and utilisation, updates to the information rules tool, transition to the single national operating model for monitoring activity (including drugs and devices) and opportunities for prime contractor delivery. We anticipate this data will inform future payment designs.

Moreover, stakeholders have told us that to address the disproportionate annual growth in prescribed specialised service expenditure, a greater level of service redesign may be needed. Such redesigns can only be achieved over a period of years.

Given these considerations, it is our view that, having regard to their contractual duties and patients' rights under the NHS constitution, providers of specialised services should make every effort to deliver care that is clinically appropriate and cost effective to contribute to managing demand, where their clinicians have significant influence. A fair and simple way to incentivise these behaviours is to create a contractual environment which promotes shared ownership of this challenge through introducing 50:50 gain and loss sharing provisions.

We consider such policy intervention to be warranted, on balance, since rapidly growing expenditure that exceeds population prevalence growth is unlikely to reflect efficient and effective services, which are in patients' best interests overall. In particular, guidance alone is unlikely to prompt the necessary widespread behaviour change to moderate disproportionate expenditure growth. However, to mitigate the potential for patients being impacted adversely (for example through reduced access or quality), we have made it explicit that NHS England teams and providers' clinicians should agree quality and access measures that must be monitored regularly (see subsection 8.3.4 below). These arrangements reinforce existing requirements already in the NHS Standard Contract.

[194] http://www.england.nhs.uk/2014/10/03/intentions/

8.2. New payment arrangements for 2015/16

It is the view of NHS England and Monitor that it is appropriate to introduce changes to national variations and local price-setting rules for the '2015/16 National Tariff Payment System' that have the effect of sharing any financial gains and losses between NHS England and providers relative to a stated financial base level. This section sets out the new national variation and rules for determining local prices for acute prescribed specialised services:

- **Default 50:50 gain and loss sharing**: a new national variation and local price-setting rule which has the effect of sharing financial gains and losses 50:50 around a stated financial base value.
- **Good practice guidance and rules**: to encourage NHS England teams and providers to negotiate innovative local payment arrangements that enable the adoption of the most efficient service models; we provide guidance and rules on, among other things, key factors to be considered.

8.2.1. Default 50:50 gain and loss sharing: national variation and rules

NHS England and Monitor are introducing a national variation and a local price-setting rule in determining payment arrangements for acute prescribed specialised services. The national variation and local price-setting rule described below are a new **default** payment arrangement.

NHS England and Monitor recognise that in some places innovative local payment arrangements are being agreed to support new models of care, for example developing a capitation-based payment for an entire pathway. The new variation and rule enable services subject to such payment arrangements to be excluded from the **default 50:50 gain and loss sharing** arrangement where appropriate.

The new arrangement has the effect of sharing any financial gains and losses between NHS England and providers from a **stated base value**. It is difficult to determine empirically the appropriate level of the gain and loss share, so we have sought to share financial risk equally between providers and the NHS England. Further, it is our view that, as all acute prescribed specialised services (both nationally and locally priced) would benefit from partnership working, the **default 50:50 gain and loss sharing** will cover all acute prescribed specialised services, including the high cost drugs and devices used in the provision of those services.

As contracts for acute prescribed specialised services cover services that have national prices and local prices, a combination of a new national variation and a new local price-setting rule are required to bring about the effect that financial gains and losses are shared on a 50:50 basis, in relation to a nationally determined stated base value.

The variation and rule would apply before the application of the Commissioning for Quality and Innovation (CQUIN) payment, local incentive schemes and contractual financial sanctions. In other words, those payments or sanctions will be calculated on the value of services after adjustment to prices in accordance with the variation and rule.

Definitions for national variation and local price-setting rule for acute prescribed specialised services

In the national variation and rules for local price-setting rule set out below, the following definitions apply:

- 'acute prescribed specialised services' means the services, other than mental health services, prescribed in Schedule 4 to the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012[195]
- 'excluded services' means the services where the payments in respect of those services are excluded from step D2 of the calculation in section 8.3.2 (services subject to innovative alternative local payment arrangements)
- 'Gross specialised actual contract value' means, in relation to a financial year, the amount payable to the provider based on the actual activity levels and the prices agreed in the contract for that year (before application of the national variation and rule 1 of local price-setting rules for acute prescribed specialised services), less:
- any amounts paid or payable in respect of services other than acute prescribed specialised services;
- any payments deducted from the stated base value under item D1 of the calculation in section 8.3.2 (additional payments);
- any amounts paid or payable in respect of excluded services,
- and before the application of CQUIN, local incentives schemes[196] and any contractual financial sanctions
- 'local payment approaches' means arrangements for prices that involve local variations, local modifications or local price-setting
- 'Stated base value' means the value for the financial year 2015/16 calculated in accordance with section 8.3.2 below (setting a baseline contract value).

[195] S.I. 2012/2996, as amended.
[196] As defined I the NHS Standard Contract, set out in Schedule 4, Part F.

National variation for acute prescribed specialised services:

The variation applies to the national prices payable by NHS England for acute prescribed specialised services where those services are provided under a commissioning contract or proposed commissioning contract with NHS England. The variation applies to such a service unless NHS England and the provider have agreed an innovative local payment approach in relation to that service that supports the adoption of more efficient service models (in accordance with step D2, in calculating the stated base value, described in section 8.3.2).

The variation operates as follows.

(1) Where the gross specialised actual contract value for the financial year 2015/16 exceeds the stated base value, the national prices must be varied such that, taken together with both:

(a) any other applicable national variation, local variation or local modification

(b) the prices for the locally priced acute prescribed specialised services under the contract

the amount payable to the provider in respect of the provision of acute prescribed specialised services (other than excluded services) in that year is the sum of the Stated Base Value and 50% of the amount by which the Stated Base Value has been exceeded.

(2) Where the gross specialised actual contract value for the financial year 2015/16 is less than the Stated Base Value, the national prices must be varied such that, taken together with:

(a) any other applicable national variation, local variation or local modification

(b) the prices for the locally priced acute prescribed specialised services under the contract

the amount payable to the provider in respect of the provision of acute prescribed specialised services (other than excluded services) in that year is the stated base value, less 50% of the difference between the two values.

(3) No variation applies if the gross specialised actual contract value equals the stated base value.

Rule 1 of the local price-setting rules for acute prescribed specialised services

(1) This rule applies to the local prices payable by NHS England for acute prescribed specialised services, where those services are provided under a commissioning contract or proposed commissioning contract with NHS England. The variation applies to such a service unless NHS England and the provider have agreed an innovative local payment approach in relation to that service which supports the adoption of more efficient service models (in accordance with step D2, in calculating the stated base value, described below).

(2) Where the gross specialised actual contract value for the financial year 2015/16 **exceeds** the stated base value, the local prices must be set such that, taken together with the prices for the nationally priced services under the contract as varied in accordance with the national variation above, the amount payable to the provider in respect of the provision of acute prescribed specialised services (other than excluded services) in that year is the sum of the stated base value and 50% of the amount by which the stated base value has been exceeded.

(3) Where the gross specialised actual contract value for the financial year 2015/16 **is less than** the stated base value, the local prices must be set such that, taken together with the prices for the nationally priced services under the contract as varied in accordance with the national variation above, the amount payable to the provider in respect of the provision of acute prescribed specialised services (other than excluded services) in that year is the Stated Baseline Value, less 50% of the difference between the two values.

(4) Where the gross specialised actual contract value **equals** the stated base value, local prices must be set such that, taken together with the prices for the nationally prices services under the contract as varied in accordance with the national variation above, the amount payable to the provider in respect of the provision of acute prescribed specialised services (other than excluded services) in that year is the stated baseline value.

Where the default national variation and local price setting rule is applied, NHS England teams should ensure that contractual quality schedules contain sufficient measures to assure the quality of care outcomes and patient experience delivered and patients’ rights under the NHS Constitution.

8.2.2. Good practice guidance and rules: negotiating local prices

NHS England and Monitor recognise that in some places innovative local payment arrangements are being agreed to support new and more efficient models of care. One example of this is developing a capitation-based payment for clinical pathway. The national variation and local pricing rule above therefore provide that such services are excluded from the scope of gain and loss sharing, where it would not complement or enhance these innovative arrangements. The good practice guidance

and rules below should however be applied to the setting of prices for those services.

Furthermore, to determine the specialised contract outturn value, NHS England teams and providers must still agree initial local prices. The final price paid will then be subject to the **Default 50:50 gain and loss sharing** arrangement set out in the previous section. The initial prices must be agreed in accordance with the rules and guidance set out below.

So, for 2015/16, NHS England's teams will engage constructively with providers at an early stage and negotiate prices, which reflect patient needs, aim to enable the adoption of the most efficient service models and which secure sustainable financial savings for both the provider and the commissioner. This means that it is essential all parties enter into the contracting process committed to finding a negotiated outcome that supports a model of care that best delivers value for patients, including where this means bringing difficult trade-offs to light such as decommissioning services from some providers or changing clinical thresholds for treatment. All relevant information and data should be taken into account and shared appropriately.

NHS England teams and providers should seek to agree local prices for acute prescribed specialised services that reflect the following guidance and rules (in place of those specified in Section 7.4):

Additional local price-setting rules for acute prescribed specialised services:

These rules apply subject to **Rule 1** (**default 50:50 gain and loss sharing** arrangements for acute prescribed specialised services).

Rule 2: NHS England and providers must apply the principles in Section 7.1 when agreeing prices for acute prescribed specialised services without a national price.

Rule 3: NHS England and providers should have regard to the national tariff efficiency and cost uplift factors for the relevant financial year (as set out in Section 5) when setting local prices for acute prescribed specialised services without a national price for the relevant financial year, if those services had locally agreed prices in the previous financial year.

Rule 4:

(a) Where there is a national currency specified for an acute specialised service in Annex 7A of this document, the national currency must be used as a basis for local price-setting for the services covered by those national currencies, unless an alternative payment approach has been agreed in accordance with Rule 5 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 for locally determined prices.

(c) The completed templates must be submitted to Monitor by 30 June 2015.

Rule 5:

(a) Where there is a national currency specified for an acute prescribed specialised service, but NHS England and a provider of that service wish to not use that currency, NHS England and the provider may agree a price without using the national currency. When doing so, NHS England teams and providers must adhere to the requirements in paragraphs (b) to (e) below, which are intended to mirror the requirements for agreeing a local variation for a service with a national price, as set out in subsection 7.2.

(b) The agreement must be documented in the commissioning contract between NHS England and the provider which covers the service in question.

(c) NHS England 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) NHS England must have regard to the guidance in subsection 7.2.3 when preparing and updating the written statement.

(e) NHS England must submit the written statement to Monitor.

Rule 6: In negotiating prices for an acute prescribed specialised service not subject to a national price, NHS England and the provider should:

(a) make steps towards convergence to efficient benchmark values (subject to significant differences in service specifications)

(b) be informed by full disclosure by the provider of the actual costs of care, including at a patient level where these are available, and analysis of the provider's relative position on the reference cost index for each service

(c) review any existing arrangements for gain sharing for high cost drugs and devices which are currently paid for on a pass through basis

(d) adhere to maximum reference prices when determining high cost drug and device spending

(e) take into account activity plans that support agreed service redesigns, which may include some services being decommissioned or changes to clinical thresholds.

8.3. Guidance on applying the new payment arrangements

This section aids NHS England's teams and providers in applying the new payment arrangements by providing further detail on, how the stated base value must be set, how to establish the value of gains and losses, what monitoring arrangements must be in place through contracts and a worked example for applying the **default 50:50 gain and loss sharing**.

8.3.1. Applying the Default 50:50 risk sharing arrangements

The new national variation and local payment rule require that the **default 50:50 gain and loss sharing** arrangement is applied to all acute prescribed specialised services except where the option is exercised to exclude services with agreed innovative local payment arrangements supporting new models of care. In some circumstances such innovative arrangements will require local payment variations or local modifications (see section 7.2 and section 7.3). Further to the publication of NHS England's Commissioning Intentions 2015/16 for Prescribed Specialised Services, NHS England teams and providers will be commencing contracting negotiations and planning for the coming financial year. These steps are designed to illustrate how NHS England teams and providers should work together to agree the detailed basis under which the **default 50:50 gain and loss sharing** will operate under their local contracts:

Step 1: Determine the applicable stated base contract value (stated base value) for **all** specialised services spend (including pass through high cost drugs and devices). The stated base value starts from the 2014/15 expected annual contract value (see subsection 8.3.2).

Step 2: Agree the scope of services covered by the **default 50:50 gain and loss sharing** arrangement. Services to be covered by an innovative local payment arrangement may be excluded from the **default 50:50 gain and loss sharing** arrangement at the discretion of NHS England teams, subject to provider agreement.

Step 3: Negotiate payment arrangements for locally priced services that enable the adoption of most efficient service models, in line with NHS England's commissioning intentions and the local payment rules in subsection 8.2.2.

Step 4: Review quality and access measures and targets to be reported within contractual governance mechanisms to ensure that patient care is not being compromised (see subsection 8.3.4).

Step 5: Agree the 2015/16 plan for expenditure on specialised services and calculate the expected financial adjustment for the 50:50 risk share.

Step 6: Set out a monthly profile for the stated base value and the expected risk-share adjustment for acute prescribed specialised services, against which the gross specialised actual contract value of care provided can be reconciled.

Step 7: Undertake reconciliation of the gross specialised actual contract value against the stated base value and the expected risk-share adjustment on a monthly basis in line with the provisions of Service Condition 36 of the NHS Standard Contract, making appropriate adjustments to actual payment to reflect the impact of the 50/50 risk-share:

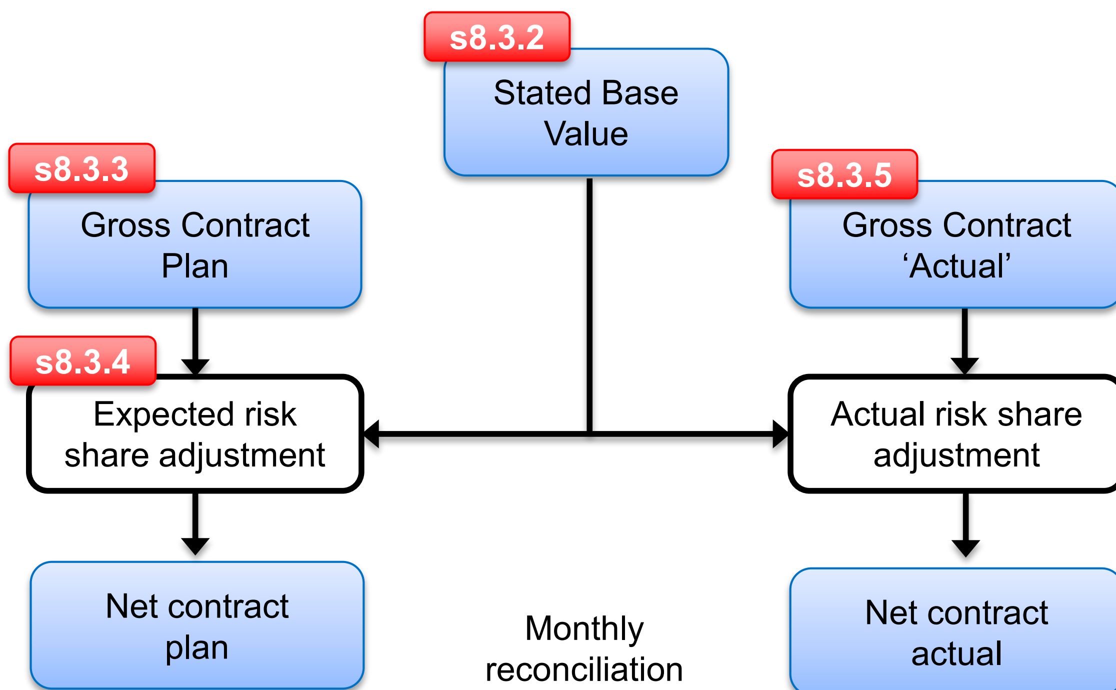
- if actual > stated base value: NHS England pays 50% of the difference
- if actual < stated base value: NHS England retains 50% of the difference.

Step 8: At the year end, undertake a final reconciliation to ensure that the correct overall adjustment to payment has been made for the year as a whole.

CQUIN payments should continue to be calculated on the basis of the specialised contract outturn for the value of services to which CQUIN applies (as set out in the Standard Contract). Any contractual financial sanctions or sums retained should then be applied, where sanctions or sums retained are calculated in reference to gross specialised actual contract value (before CQUIN payments). Any sums withheld but not retained should not impact the calculation of the gross specialised actual contract value.

The process of applying the gain and loss sharing arrangements, including references to the relevant explanatory section, is illustrated in Figure 8.1.

Figure 8.1: Applying the gain and loss sharing arrangements



8.3.2. Setting a stated base value

In 2015/16, the stated base value for the **default 50:50 gain and loss sharing** is derived from the value (£) of the 2014/15 expected annual contract value for the relevant provider of prescribed specialised services. The stated base value is therefore calculated, using the following formula:

Stated base value = (A + B – C – D1 – D2) E + F + G

A	**Start with the 2014/15 expected annual contract value (EACV) as recorded in Schedule 3F of the Particulars of the NHS Standard Contract** This value (£) should already reflect national variations made to national prices in 2014/15, so no further adjustment is required relating to payments made in accordance with: • Market Forces Factor • specialist top ups • 30-day readmission rule The EACV should also already reflect the expected impact of any agreed local variations or approved local modifications (although the latter if being continued must be resubmitted to Monitor for approval against the 2015/16 national prices).
B	**Apply any signed recorded contract variations in schedule 6A as at 1 October 2014 that affect EACV**
C	**Deduct the 2014/15 EACV for NHS England commissioned services in the contract that are not acute prescribed specialised services in 2015/16**, (such as dental specialties, screening services, offender health, community services like health visitors and family nurse practitioners and for any services commissioned under the contract by other parties such as CCGs or local authorities).
D1	**Deduct any of the following, if included in the 2014/15 EACV for acute prescribed specialised services**: • any non-recurrent payments such as winter pressures funding in 2014/15 • any non-contractual transitional support payments such as project diamond or deficit support funding in 2014/15 • any Cancer Drugs Fund payments in 2014/15

	• the contract plan value of CQUIN payments in 2014/15 • payments for Operational Delivery Networks, hosted staff, or non-clinical services in 2014/15.
D2	**Deduct the 2014/15 EACV of any services where agreement has been reached to adopt innovative alternative local payment arrangements** These arrangements should support the adoption of new and more efficient models of care that promote better value for patients. (In some circumstances such arrangements will need a local payment variation).
E	**Apply the 2015/16 national tariff cost uplift and efficiency factors to the 2014/15 EACV for prescribed specialised services**. These may be found in Section 5 of this document. The uplift and efficiency factors should not be applied to high cost drugs and devices.
F	**Recalculate the marginal rate emergency tariff adjustment at 50% at current national prices and adjust the 2014/15 EACV for prescribed services**. The marginal rate baseline activity and 2014/15 contract plan activity are unchanged. The 2015/16 national tariff cost uplift and efficiency factors should be applied to these values and the marginal rate deduction set at 50% rather than 70% of the difference between the two values. If no marginal rate is being applied to non-elective admissions, no adjustment is required.
G	**Make any adjustments (at the discretion of NHS England teams), such as:** • the full-year effect of any part-year recurrent funding investments in the 2014/15 EACV less the full-year effect of any part-year recurrent QIPP savings in the EACV at 2015/16 price levels • an adjustment to the 2014/15 EACV to reflect NHS England national forecast of new drug and device introduction in the contract year 2015/16, changes to mandatory NICE guidance and NHS England clinical policy, and prices such as use of generics for drugs coming off patent. • where decisions have been agreed with providers that will result in material changes in patient flows in 2015/16 due to service reconfiguration (such adjustments would normally be a deduction in the activity from one provider contract value at 2015/16 price levels and an equivalent addition to the activity in another provider contract value at 2015/16 price levels).

NHS England and the provider must record the final stated base value in Schedule 3I of the Particulars of the NHS Standard Contract, including the calculation steps

that translated the 2014/15 expected annual contract value into the 2015/16 stated base value – clearly describing the adjustment made to accommodate the changes to the marginal rate rule and any discretionary adjustments. Should any services be paid for under an innovative local payment arrangement, the currency and local price should be separately documented and a local variation, and/or local pricing, submitted to Monitor.[197]

8.3.3. Calculating 2015/16 gross specialised contract plan value to determine the expected risk share adjustment

A	**Start with the 2015/16 NHS Standard Contract expected annual contract value (EACV) as recorded in Schedule F** The contract plan for prescribed specialised services should be developed in the normal way based on planned activity at 2015/16 National tariff prices, and agreed local prices and national variations such as the marginal rate emergency tariff, and include planned spend on high cost drugs and devices (excluding Cancer Drugs Fund)
B	**Deduct the 2015/16 EACV for NHS England commissioned services in the contract that are not prescribed specialised services**, (such as dental specialties, screening services, offender health, community services like health visitors and family nurse practitioners and for any services commissioned under the contract by other parties such as CCGs or local authorities).
C	**Deduct the 2015/16 contract plan value for CQUIN Payments,** if this has been included in the gross EACV (NOTE: CQUIN payments should not be included in the gross EACV, according to contract definitions)
D	**Deduct any of the following, if included in the 2015/16 EACV for acute prescribed specialised services**: • any planned non-recurrent payments such as winter pressures funding in 2015/16 • any planned non-contractual transitional support payments such as project diamond or deficit support funding in 2015/16 • any planned Cancer Drugs Fund payments in 2015/16 • payments for Operational Delivery Networks, hosted staff, or non-clinical services in 2015/16
E	**Deduct from the 2015/16 contract plan the value of any services deducted**

[197] See Section 7 for information on locally determined prices.

	from the scope of the base value (under D2 above)
F	**The resulting value is used as the 50:50 risk share gross specialised contract plan value**

8.3.4. Calculating the Expected Monthly Risk Share Adjustment

The expected gain and loss share adjustments should be applied on a monthly basis, using agreed monthly phasing to determine the 2015/16 expected annual contract value used for monitoring.

A	**Compare the gross specialised contract plan value with the stated base value. Half of the difference is the expected risk share adjustment.**
B	Deduct the expected risk share adjustment from the gross EACV to finalise the EACV to be recorded in Schedule 3F of the contract and to be used for monitoring
C	The expected risk share adjustment should be applied on a monthly basis using an agreed monthly phasing

8.3.5. Establishing actual gains or losses and adjusting payments in-year

To establish the financial gains or losses to be shared between NHS England teams and providers on a 50:50 basis, the gross specialised actual contract value for the financial year 2015/16 must be established. This can then be compared against the stated base value to determined actual gains or losses. Where these values differ from the expected risk share adjustment, payments should be adjusted as part of the financial reconciliation process.

The gross specialised actual contract value for the relevant financial year should be calculated using the following method:

Gross specialised actual contract value = A – B – C – D – E

A	**Determine the amount payable to the provider based on the actual activity levels and the prices agreed in the contract for that year** (before application of the national variation and rule 1 of local price-setting rules for acute prescribed specialised services).
B	**Deduct any amounts paid or payable in respect of NHS England commissioned services in the contract that are not acute prescribed**

	specialised services, (such as dental specialties, screening services, offender health, community services like health visitors and family nurse practitioners and for any services commissioned under the contract by other parties such as CCGs or local authorities).
C	**Where any of the following have been included in the acute prescribed specialised services contract plan, deduct the 2015/16 actual value of:** - any non-recurrent payments, such as winter pressures funding - any non-contractual transitional support payments, such as project diamond or deficit support funding (note: it is likely these would not appear in the contract plan) - any Cancer Drugs Fund payments - any payments for Operational Delivery Networks, hosted staff, or non-clinical services The planned value of these payments would also have been deducted from the stated base value (see item D1 in subsection 8.3.2).
D	**Deduct the 2015/16 actual value of any services deducted from the scope of the stated base value** (these are the 'excluded services' deducted from the stated base value – see item D2 in subsection 8.3.1).
E	**Deduct the actual 2015/16 contract value for CQUIN Payments,** if these payments have been included in the amount payable in row A above
F	**The resulting value is used as the gross specialised actual contract value**
G	**Compare the gross specialised actual contract value** with the stated base value to determine the actual monthly risk share adjustment for the month in question.
H	**Compare the actual monthly risk share adjustment with the expected monthly risk share adjustment for the month**, as part of the monthly financial reconciliation process under Service condition 36 of the NHS standard Contract. Adjust the actual payment between commissioner and provider accordingly, so that the actual payment fully reflects the actual impact of the risk-share arrangement.

The actual risk gain and loss share adjustments should be applied on a monthly basis. At the year end NHS England and providers must undertake a final reconciliation to ensure that the final amount paid accords with the default 50:50 gain and loss sharing arrangement set out in subsection 8.2.1.

8.3.6. Quality and service monitoring arrangements

It is important that NHS England teams and providers use existing contract monitoring arrangements to track the impact of gain and loss sharing on the value of activity levels and patients. In addition to monitoring the observed variance in activity levels and activity value, the introduction of gain and loss sharing also requires scrutiny of the quality of care delivered.

As part of their contracts, NHS England teams will have agreed with their providers a suitable set of quality measures and targets that can provide a timely indication of clinical outcomes and patient experience. These measures should reflect a broad definition of quality, including clinical outcomes, patient experience and safety. Within the domain of patient experience, measures that reflect access, waiting times and choice, should be considered, to ensure that patients' rights, as set out in the NHS Constitution, are observed. It is good practice that these measures are supported by the providers' clinicians and patient groups.

8.3.7. Worked example

A worked example is included as a supporting document to this section: 'Worked example to Default 50:50 gain and loss sharing rule'.[198] This is an excel tool into which NHS England teams and providers can input their own data.

[198] This supporting document and all related documents are hosted at: www.gov.uk/government/consultations/national-tariff-payment-system-201516-a-consultation-notice

9 Payment rules

The Health and Social Care Act 2012 ('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).[199] In this section, we set out the rules for:

- billing and payment
- activity reporting.

9.1 Billing and payment

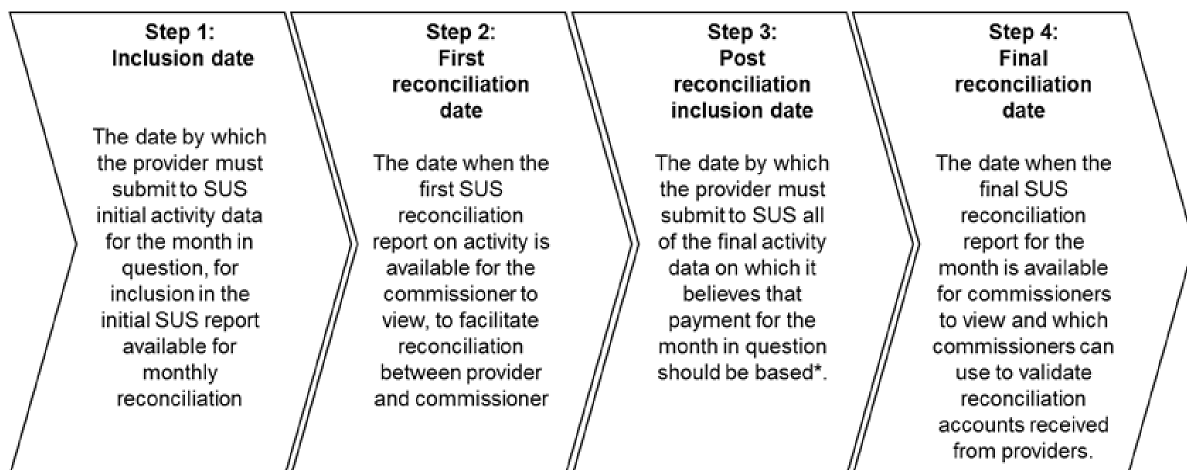
Billing and payment must be accurate and prompt, in line with the terms and conditions set out in the NHS Standard Contract. Payments to providers may be reduced or withheld in accordance with provisions for contractual sanctions, such as those in the NHS Standard Contract (eg sanctions for breach of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

9.2 Activity reporting

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

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

Figure 9.1: 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*

199 2012 Act, section 116(4)(c).

commissioners, as set out in the NHS Standard Contract. Any subsequent amendments or corrections to the data on SUS, after the post-reconciliation inclusion date, should not affect payments to be made by the commissioner.

The 2015/16 dates for reporting monthly activity and making the reports available will be published on the Health and Social Care Information Centre (HSCIC) website.[200] HSCIC will automatically notify subscribers to its e-bulletin when these dates are announced.

The Secretary of State for Health has approved the NHS England application for support under Regulation 5 of the Health Service (Control of patient information) Regulations 2002 (Section 251 support). This allows clinical commissioning groups (CCGs) and commissioning support units (CSUs) to process personal confidential data, which are required for invoice validation purposes. This approval is subject to a set of conditions. NHS England has published advice online[201] about these conditions and sets the actions that CCGs, CSUs and providers must take to ensure they act lawfully.

[200] http://www.hscic.gov.uk/sus/pbrguidance

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

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