Monitor
Making the health sector work for patients

Guidance on locally determined prices

A supporting document for the 2016/17 National Tariff Payment System

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Contents

Introduction

The rules that commissioners and providers must follow to agree local variations and local prices, and the methods that Monitor will use to consider local modifications, are set out in Section 6 of the *2016/17 National Tariff Payment System*. In this supporting document, NHS England and Monitor provide guidance on the related processes for local variations, modifications and prices.

This document is divided into six sections:

1. Background and overview of process for agreeing locally determined prices
2. Constructive engagement
3. Agreeing and publishing a local variation
4. Preparing evidence for a local modification
5. Submitting a local modification agreement or application
6. Submitting local price information

The annexes to this document contain further guidance on specific calculations.

We plan to update this supporting document for locally determined prices in the future as we develop our understanding of how these policies are working in practice.

1. Background and overview of process for agreeing locally determined prices

NHS England and Monitor have developed a principles-based framework that applies to all local variations, modifications and prices. This process is set out in Section 6 of the *2016/17 National Tariff Payment System*. In this section, we provide an overview of the process for agreeing locally determined prices, and then a summary of local variations, local modifications and local price-setting.

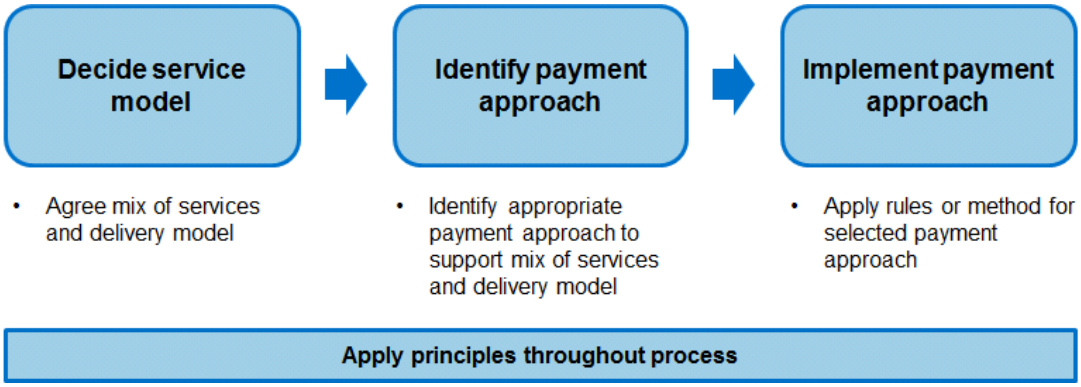
1.1. Framework for locally determined prices

The framework for locally determined prices incorporates three principles to be applied by commissioners and providers:

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

Our rules for local variations and prices specifically require commissioners and providers to apply these principles. Our method for assessing local modifications also involves ensuring that commissioners and providers have acted in accordance with the principles when seeking to agree a modification. In addition to the principles themselves, the framework involves a common process to be applied to all locally determined prices, as summarised in Figure 1-1 below.

Figure 1-1: Process for agreeing local variations, modifications and prices



Local payment approaches only apply to the services specified in the relevant agreement, and for the parties to that agreement (with the exception of local modification applications approved by Monitor, which apply to all commissioners that purchase the relevant services unless otherwise specified by Monitor). For activity that is not covered by a written contract between a provider and a commissioner (often referred to as 'non-contract activity') we suggest that providers and commissioners follow the advice in NHS England's guidance document, *Who pays? Determining responsibility for payments to providers*.

1.2. Local variations

Under our rules, commissioners and providers can use local variations to agree adjustments to national prices or the related currencies[1]. As such, local variations are the main mechanism through which commissioners and providers can design alternative payment approaches that better support the services required by patients. Local variations are explained in Section 6 of the *2016/17 National Tariff Payment System*.

1.3. Local modifications

Local modifications are intended to ensure that health care services can be delivered where they are required by commissioners for patients, even if the cost of providing services is higher than the national price.[2]

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1 Local variations are permitted under sections116(2)(a) and (b) of the 2012 Act.

2 The legislation governing local modifications is laid out in Chapter 4 of Part 3 of the 2012 Act. The legal framework for local modifications is principally described in sections 116, 124, 125 and 126.

There are two types of local modifications:

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

Under the Health and Social Care Act 2012 (the '2012 Act'), Monitor is required to publish in the national tariff its method for deciding whether to approve local modification agreements and for determining local modification applications. Under the methods, set out in Section 6 of the *2016/17 National Tariff Payment System*, 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.[3]

For both agreements and applications, Monitor must be satisfied that it would be uneconomic for the provider to provide specific services without local modification.[4] If Monitor is not satisfied this is the case, we will not approve a local modification agreement or grant a local modification application. Local modifications are explained in Section 6 of the *2016/17 National Tariff Payment System*.

1.4. Local prices

For many NHS services, there are no national prices. Some of these services have nationally specified currencies, but others do not. In both cases, commissioners and providers must work together to set prices for these services. The 2012 Act allows Monitor and NHS England to set rules for local price-setting for such services, including rules specifying national currencies for such services.[5]

We have set both general rules and rules specific to particular services.

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[3] 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 cases, we would encourage providers and commissioners to submit agreements/applications that cover multiple services.

[4] 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.

[5] 2012 Act, sections116(4)(b) and 118(5)(b).

There are two types of general rule:

- rules that apply to all cases when a local price is set for services without a national price (see below)
- rules that apply only to local price-setting for services with a national currency (but no national price).

These rules are explained in Section 6 of the *2016/17 National Tariff Payment System*.

The following rules apply when providers and commissioners set local prices for services without national prices. The rules apply irrespective of whether or not there is a national currency specified for the service.

Rule 1: Providers and commissioners must apply the principles in Section 6.1 when agreeing prices for services without a national price.

Rule 2: Commissioners and providers should have regard to the efficiency and cost uplift factors adopted under the ETO for 2015/16 and the efficiency and cost uplift factors for 2016/17 (as set out in Section 4 of this document) when setting local prices for services without a national price for 2016/17.[6]

Where providers have already taken the ETO efficiency and cost uplift factors into account when agreeing local prices in 2015/16 then they have already satisfied that part of Rule 2, assuming that the 2015/16 price is used as the basis for negotiations in 2016/17. The amendment is therefore intended to address those commissioners and providers who did not proceed on this basis in 2015/16 (ie some or most DTR providers).

[6] The efficiency factor and cost uplift factors under the ETO were -3.5% and 1.9% respectively. This leads to an overall adjustment of -1.6% for 2015/16.

2. Constructive engagement

As explained in Section 6 of the *2016/17 National Tariff Payment System*, the process for agreeing locally determined prices requires commissioners and providers to engage constructively with each other. Constructive engagement is also a requirement of Condition P5 of the Provider Licence and the Monitor NHS and NHS Trust Development Authority Partnership Agreement, in cases where a provider believes that a local modification is required.[7]

Providers and commissioners must engage constructively with each other to decide on the mix of services, delivery model and payment approach that delivers the best value for patients in their local area. This process should involve clinicians, patient groups and other relevant stakeholders where possible. It should also facilitate the development of positive working relationships between commissioners and new or existing providers over time, as constructive engagement is intended to support better and more informed decision-making in both the short- and long-term.

Commissioners and providers should 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?[8]
- **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 relevant clinicians and other stakeholders** – Are relevant clinicians and other stakeholders, such as patients or service users, involved in the decision-making process?
- **Short- and long-term objectives** – Are clearly defined short- and long-term strategic objectives for service improvement and delivery agreed before starting price negotiations?

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7 See Condition P5 of the Provider Licence. NHS trusts must also comply with this condition under the standards agreed between Monitor and the NHS Trust Development Authority in their partnership agreement.

8 The NHS Standard Contract is used by commissioners of health care services (other than those commissioned under primary care contracts) and is adaptable for use for a broad range of services and delivery models.

We believe that these requirements will be consistent with existing practice for many providers and commissioners. However, we recognise that this will not always be the case, particularly in circumstances where providers and commissioners do not have existing contractual relationships.

In this guidance, we set out a framework that could be used as a guide to facilitate constructive engagement in cases where commissioners and providers do not already have a framework in place. It includes four stages, which are explained in more detail in the subsections below. In summary, to implement the framework in full, providers and commissioners would have to:

- **Establish a working group** for contract negotiations in relation to locally determined prices (see Subsection 2.1)
- **Define roles and responsibilities** for members of the working group, including relevant clinicians and other stakeholders, where appropriate (see Subsection 2.2)
- **Agree objectives, timescales and rules** for the working group, including rules on information sharing, deadlines and the responsibilities of each party when providing or handling information for contract negotiations (see Subsection 2.3)
- **Document progress and outputs** for the working group and contract negotiation, including any planned evaluation, if appropriate (see Subsection 2.4).

Using this suggested approach would be one way of demonstrating compliance with our requirements for constructive engagement. This is likely to be particularly relevant for providers seeking to apply for a local modification without agreement from their commissioners.[9] We would expect providers to be able to demonstrate that they have sought to apply this or a similar framework, when applying for a local modification.

[9] See Section 6 of the *2016/17 National Tariff Payment System*.

2.1. Establish a working group

Providers and commissioners that use our framework should establish a working group, or designate an existing group, to take responsibility for local variations, modifications and prices in contract negotiations. The working group should:

- include appropriate representatives from the provider and commissioner, including senior clinical, financial and operational representatives
- have the authority to make commitments on behalf of the organisations represented.

Providers and commissioners are responsible for establishing a working group and should not require Monitor's involvement.

2.2. Define roles and responsibilities

For the working group to be effective, it should agree and document the roles and responsibilities of the members of the group, and the group as a whole. These may include the following:

- selection of a chairperson to lead the working group. The working group could be jointly chaired or the chair could rotate between represented groups if appropriate. Alternatively, an independent, jointly chosen and endorsed chair may also be appropriate
- agreement on the representation required at each meeting of the working group for it to be quorate
- agreement on a timetable of meetings for the working group and a process for recording and approving minutes of the meetings, and other administrative processes.

Relevant clinicians and patient group representatives should be involved in the negotiation process and be invited to join working group meetings where appropriate. The involvement of clinicians and patients with front-line experience is important when determining how quality and efficiency may best be balanced, particularly across a range of services.

2.3. Agree objectives, timescales and rules

Under our proposed framework, the working group should agree clear objectives, timescales and rules, including policies on information sharing and, where appropriate, processes to resolve disputes when the working group is not able to achieve its objectives.[10] We explain each of these elements below.

2.3.1. Objectives

Providers and commissioners should agree short- and long-term objectives as part of their framework for negotiations. We would generally expect the working group to:

- clearly define the issues and the services that are within scope of the working group
- set specific objectives in relation to each issue or group of services that is within scope
- agree when the objectives must be completed and how they should be measured
- agree a process for updating or changing objectives when appropriate
- agree clear long-term objectives that are consistent with the strategic plans of the parties in the working group.

2.3.2. Timescales

Under our framework, we would expect the working group to agree a timescale and a deadline for agreeing local variations, modifications and prices. The timescale should include specific milestones and named individuals who are responsible for delivery.

2.3.3. Rules

We would encourage the working group to agree rules or guidelines that facilitate constructive engagement and effective contract negotiation.

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[10] This might be appropriate, for example, where local variations or modifications make up a small part of the total contract value.

2.3.4. Information sharing

The working group is most likely to be effective if it has access to relevant and accurate information that is provided in a timely manner and agreed by all parties. Information requests should be proportionate, recognising the cost of preparing and providing information to the group.

On this basis, we would expect the working group to decide what information is needed to agree local variations, local modifications or local prices. We would also expect the working group to set rules or guidelines on the way information is provided and used, including rules or guidelines on maintaining commercial confidentiality.

2.3.5. Resolving disputes

In negotiations with respect to prices that apply under an existing commissioning contract, any dispute should be resolved using the procedure for dispute resolution under that contract. For contracts yet to be entered into (including contracts that will replace existing contracts), the working group may wish to agree a dispute resolution process in case it is unable to reach agreement on local variations, modifications or prices. It may be useful for the working group to:

- consider assistance that could be available from other organisations, for example support and advice from Commissioning Support Units (CSUs) and NHS England's regional teams
- replicate the provisions for dispute resolution in the NHS Standard Contract[11]
- agree when and how the working group should use these dispute resolution options.

[11] These provisions allow for support by third party organisations such as the Centre for Effective Dispute Resolution (CEDR) to help resolve disputes.

2.4. Document progress and outputs

The working group should document its progress and outputs. In addition to meeting minutes, we would expect the working group to prepare a constructive engagement report, which states the following:

- the agreed roles and responsibilities of the working group, including a list of its main representatives and the chair or co-chair
- the agreed objectives of the working group and the services covered
- a list of the meetings of the working group
- a clear statement of the outcome of the process, including points of agreement and disagreement.

This information could be used as evidence of compliance with the requirements for constructive engagement set out in Section 6 of the *2016/17 National Tariff Payment System*.

In addition to the constructive engagement report, we encourage working groups to evaluate the payment approaches they agree, to inform future negotiations.

3. Agreeing and publishing a local variation

Commissioners and providers can use local variations to agree adjustments to national prices or related currencies.[12] As such, local variations are the main mechanism through which commissioners and providers can design alternative payment approaches that better support the services that patients need. This may be desirable in a variety of situations, for example:

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

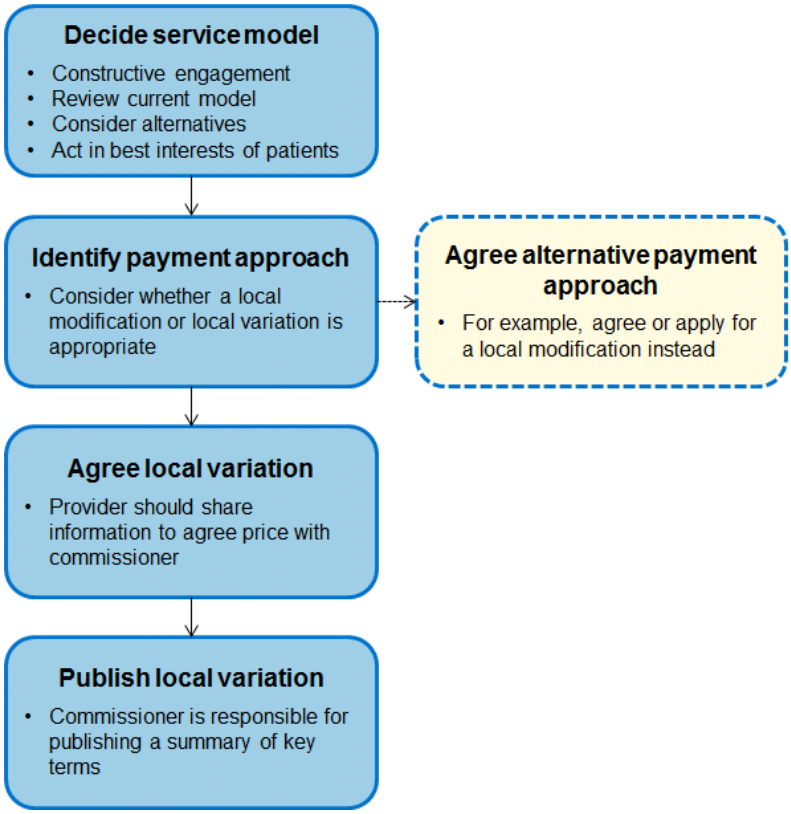
Local variations replace what was previously referred to as 'local flexibilities'. The rules that commissioners and providers must follow when agreeing local variations are set out in Section 6 of the *2016/17 National Tariff Payment System*.

The guidance in this section also applies to agreements to depart from national currencies for local pricing, under Rule 4 in Section 6 of the *2016/17 National Tariff Payment System*.

[12] Local variations are permitted by the rules made under section 116(2) of the 2012 Act.

The process for agreeing a local variation is summarised in Figure 3-1 below. This process requires commissioners and providers to engage constructively to review the current service model, consider alternatives, and decide on a service delivery model that is in the best interests of patients. After the service model has been decided, the provider and commissioner must identify the appropriate payment approach and, in the case of a local variation, agree a local variation to national prices and/or currencies. Under the 2012 Act, all agreed local variations must be recorded and published. These agreements do not require Monitor's approval to have effect.

Figure 3-1: Overview of process for agreeing local variations



This section provides guidance on the publication requirements summarised in the final box in Figure 3-1 above. Specifically we explain:

- the template that commissioners must use to record and publish local variations
- the process for publishing a local variation.

3.2. Local variations template

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

Under the 2012 Act, commissioners must maintain and publish a written statement of an agreed local variation.[13] These statements (which can be combined for multiple services) must include details of previously agreed variations for the same services.[14] All local variations, even those agreed as 'flexibilities' in previous years, must be recorded and published according to the new rules for local variations outlined in Section 6 of the *2016/17 National Tariff Payment System*.

Monitor may include guidance in the national tariff on how commissioners should maintain and publish a written statement, to which commissioners must have regard[15]. As set out in the *2016/17 National Tariff Payment System*, Monitor's guidance is as follows:[16]

- A local variation applies to an individual service for which there is a national price (eg a HRG). In practice, commissioners and providers are likely to agree the same or similar local variations to a range of related services. Commissioners may comply with their statutory duty to publish a written statement by publishing a single statement covering a number of related local variations.
- Commissioners should use the template provided by Monitor to prepare the written statement. (The template and a worked example can be downloaded from Monitor's Pricing Portal at https://ldp.monitor-nhsft.gov.uk/Pages/Search.aspx.) The completed template should be included in the commissioning contract (Schedule 3 of the NHS Standard Contract).

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13 2012 Act, section 116(3).
14 2012 Act, section 116(3)(b).
15 Commissioners have a duty to have regard to guidance in the national tariff on the information that should be included in the written statement. See the 2012 Act, section 116(7).
16 The guidance is included in Section 6 of the *2016/17 National Tariff Payment System*, but is included here for convenience. As it is included in the national tariff, commissioners have a statutory duty to have regard to the guidance (see section 116(7) of the 2012 Act).

- The commissioner must also submit a written statement of the local variation (using the local variation template) to Monitor. The deadline for submitting the statement is 30th June 2016. For variations that are agreed after this date, the deadline is 30 days after the date of the variation agreement. Commissioners should refer to instructions on Monitor's Pricing Portal for information on how to submit completed templates for publication, and should take additional steps to publish the details of their agreed local variations on their own websites.[17]
- The 2012 Act requires that the statement is maintained as well as published. Commissioners must therefore update the statement if they agree changes to the variations covered by the statement. If they agree any new local variations, a new statement should be published, which incorporates details of previous local variations.

The local variations template developed by NHS England and Monitor for commissioners to use when recording and publishing local variations can be downloaded from Monitor's website. The template includes detailed guidance on how to complete specific fields. Answers should be clear and concise.

This template is also to be used when a commissioner and provider agree to depart from a national currency for local pricing (see Rule 4 in Section 6 of the *2016/17 National Tariff Payment System*).

The template is divided into five sections:

1. **Background information** (mandatory) – an overview of the local variation, the type of variation being submitted, the commissioners and providers who are party to the agreement and the duration of the agreement.
2. **Service delivery model** (mandatory) – the planned service delivery model and rationale for any changes.
3. **Local variation details** (mandatory) – the national currencies and/or prices to be varied and the new payment approach agreed, including annual spend, process for reaching agreement, allocation of financial risk and which patient groups are impacted. The **currency and price table** forms part of this section.

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

4. **Additional considerations** (recommended) – the quality of care, any wider impact and risks to be considered and an overview of any planned evaluations.

5. **Contact details** (mandatory) – contact details for queries about this local variation.

All information included in the template will be made publicly available and should therefore not include any information identifying individual patients. In addition, it should not include any other information which is confidential to third parties, unless consent has been obtained.

Local variations apply to national prices before the application of national variations (but national variations still apply). Where applicable, a single local variation template can be used to record local variations for multiple services at the same time, provided the reasons for the local variations are similar. Preparing a single statement in this way, covering a number of related local variations, meets the statutory duty of commissioners.

It is the responsibility of the commissioner to ensure that the information provided in this template is a fair and accurate summary of the local variation and that the local variation is consistent with the rules set out in the national tariff. If a commissioner and provider agree changes to a local variation before the agreement end date, a new template must be published with reference to the previously agreed variation. Providers should support commissioners in fulfilling these responsibilities.

3.3. Process for publication

As outlined in Section 6 of the *2016/17 National Tariff Payment System*, under the 2012 Act, commissioners must maintain and publish a written statement of an agreed local variation[18]. These statements (which can be combined for multiple services) must include details of previously agreed variations for the same services.[19] In addition, the rules for local pricing require publication of a written statement of any agreement to depart from a national currency for local prices.[20]

To submit a written statement of a local variation to Monitor, commissioners should complete the local variations template and submit it via Monitor's Pricing Portal. A worked example can be downloaded from the Pricing Portal

When submitting a local variations template to Monitor, the relevant commissioning officer must state their full name and position and include a written declaration (either in the email sent to Monitor, or attached as a separate document). The written declaration must confirm that:

- the named officer is authorised to submit the local variations template on behalf of the commissioners identified within it
- the template accurately sets out the variation agreed by those commissioners.

Monitor will publish these templates on its website so that all agreed local variations are accessible to the public from a single location. Where Monitor publishes the template, it will do so on behalf of the commissioner for the purposes of section 116(3) of the 2012 Act (the commissioner's duty to publish a written statement). Commissioners may, however, take other additional steps to publish the details of the local variations (e.g. making the written statement available on their own website).

The completed template should be:

- included in Schedule 3, Part B, of the Particulars of the NHS Standard Contract (or equivalent if the Standard Contract is not being used)
- then published within 30 days of the contract being signed, or in the case of a variation agreed during the term of an existing contract, the date of the agreement.

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[18] 2012 Act, section 116(3).
[19] 2012 Act, section 116(3)(b).
[20] See Rule 4 in Section 6 of the *2016/17 National Tariff Payment System*.

4. Preparing evidence for a local modification

Local modifications provide a mechanism to increase nationally determined prices for specific services, where a provider faces unavoidable, structurally higher costs. To comply with our method for determining whether a local modification is appropriate (set out in Section 6 of the *2016/17 National Tariff Payment System*), providers must be able to demonstrate that:

1) the average cost of providing each service is higher than the nationally determined price

2) the provider's average costs are higher than nationally determined prices as a result of structural issues that are:

- **specific:** the structurally higher costs should only apply to a particular provider or subset of providers and should not be nationally applicable
- **identifiable:** the provider must be able to identify how the structural issues it faces affect the cost of the services
- **non-controllable:** the costs should be beyond the direct control of the provider, either currently or in the past[21,22]
- **not reasonably reflected elsewhere:** the costs should not be reasonably adjusted for elsewhere in the calculation of national prices, rules or variations, or reflected in payments made under the Sustainability and Transformation Fund.

3) the provider is reasonably efficient when measured against an appropriately defined group of comparable providers, given the structural issues that it faces[23]

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[21] 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 than 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.

[22] Monitor considers CNST costs to be controllable and will not consider them to be costs arising from structural issues when assessing whether provision of a service provision is uneconomic.

[23] If a provider is not reasonably efficient when measured against an appropriately defined group of comparators, it would have to demonstrate that its costs would still be higher

4) the commissioner and provider have engaged constructively to consider alternative service delivery models, and it is not possible to deliver the care needed at the nationally determined prices.

Monitor may also take into account any payment received by a provider under the Sustainability and Transformation Fund when determining the amount of the local modification to be granted or approved.

Monitor will only approve a local modification if we are satisfied that the services in question are uneconomic, based on these requirements.[24] A commissioner and provider (in the case of agreements) or a provider (in the case of applications) must demonstrate in their submissions to Monitor that the service or services that would be covered by a local modification are uneconomic. The local modification proposed must also be based on their assessment of the reasonably efficient cost of providing the relevant services, given the structural issues faced by the provider. The local modification may not cover the full difference between a provider's costs and the national tariff price.

The supporting information required for a local modification will depend in part on the specific circumstances faced by the provider. This section provides guidance on the type of evidence that we would expect providers and commissioners to submit to demonstrate that (i) the relevant services are uneconomic, and (ii) the proposed local modification reflects a reasonably efficient cost of provision, given the structural issues faced by the provider. We set out the process for local modifications below.

To prepare the evidence necessary for a local modification, we would expect a provider to:

- demonstrate that its average costs are higher than the nationally determined price for the services covered by the local modification
- benchmark its average costs, operating efficiency and outcome measures against suitable comparators, refining the comparator group as necessary

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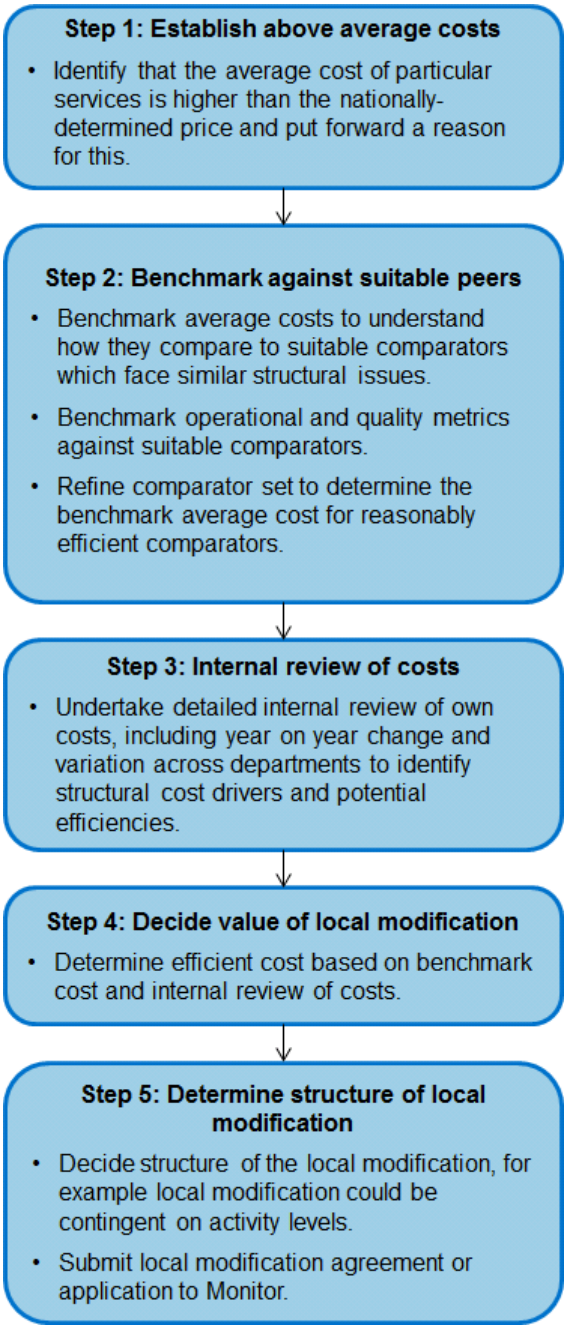
than the nationally determined price, even if it were reasonably efficient, in order to comply with NHS England and Monitor's method for local modifications.

[24] Sections 124(4) and 125(3) of the 2012 Act provide that a local modification can only be approved or granted by Monitor if Monitor is satisfied that provision of the service at the nationally determined price is uneconomic.

- present a detailed analysis of its costs which demonstrates that it faces higher costs as a result of unavoidable structural factors, and identify potential efficiencies
- propose a local modification that reflects a reasonably efficient cost of providing the services, based on the benchmarking analysis and internal review of costs performed.

This process can be broken down further into a number of steps. Figure 4-1 below summarises the process and the steps required.

Figure 4-1: Process for establishing uneconomic services



We explain each of these steps in further detail below.

4.2. Step 1: Identify services with average costs higher than the nationally determined price

The first step we would expect a provider to take would be to establish that its average costs are higher than the nationally determined price for a service or group of services. We would expect a provider to establish this as part of its ongoing analysis of operations. Having established higher than average costs, providers should explain why costs are higher due to unavoidable, structural issues, with reference to our criteria for determining structurally higher costs, as stated above.

We recognise that costing practices differ between organisations and depend on the cost allocation principles applied by each organisation. We therefore expect providers to explain cases where they have deviated from Monitor's *Approved Costing Guidance*.

When submitting a local modification to Monitor for approval, commissioners and providers should provide a detailed account to explain the issues they face in their local health economy and the drivers of structurally higher costs.

For example, structurally higher costs could be related to:

- **Scale:** certain services may require a minimum volume of procedures to be provided efficiently, as a result of the fixed or semi-fixed costs of providing them. For example, clinical best practice may require the use of specific equipment which is expensive, or clinical guidelines may stipulate the staffing mix required for a particular service. Given these requirements, providers with low patient volumes may not be cost-effective compared to the national average.[25]
- **Casemix:** certain groups of patients have greater health needs than others and are therefore more costly to treat. For example, elderly patients and people from economically deprived backgrounds may have, on average, more complex health needs. Providers in an area with a large proportion of elderly people or high deprivation might therefore face higher than average costs for providing the same services. This may not be fully reflected in the nationally determined prices.

[25] Commissioners may also have regard to the relationship between scale and clinical quality. For example, certain services may require sufficient volume in order to be provided in a clinically safe and sustainable way.

A hypothetical example is presented below to illustrate how a rural provider that faces scale issues might assess whether it meets the four criteria for identifying a structural cost difference.

Example 4-1: Criteria for identifying structurally higher costs

Consider an isolated, rural provider with a low catchment population. This type of provider could face structurally higher average costs due to geographic location and insufficient scale. This example illustrates how a provider could apply the criteria for identifying structural cost differences.

Specific
An isolated, rural provider might incur specific additional costs which do not apply nationally, for example:

- The provider may need to pay for 24 hour staff cover for a relatively low number of patients.
- The provider may not be able to recover fixed costs on certain equipment due to under-utilisation, for example, MRI scanning and CT scanning equipment.

Identifiable
The provider is able to identify and quantify the additional costs outlined above, for example, the fixed costs associated with particular equipment and the minimum level of activity required to cover these fixed costs. Step 4 in this section presents guidance on the evidence that we would expect providers and commissioners to submit to show how a particular issue impacts their reported costs.

Non-controllable
In this hypothetical example, an isolated, rural provider may not be able to control the structural cost differences that it faces for the following reasons:

- A health care service is required by the commissioner to meet the needs of the local population. Obviously, the provider is unable to influence the low population of the area and thus in turn the relatively low case volumes that it receives. As a result, it may not be able to achieve reasonable economies of scale in certain services.
- Certain clinical standards must be met regardless of the low case volumes. For example, under the Royal College of Obstetrics and Gynaecology guidelines, 5,000 births a year would typically be required for a provider to have a 24/7 obstetrics led maternity unit. However, an isolated, rural provider may require this level of specialist input to support a significantly lower level of births, in order to ensure clinical safety.

Not reasonably reflected elsewhere
In this particular example, the nationally determined prices may not fully reflect the structural cost differences faced by the provider. Whilst the Market Forces Factor (MFF) is intended to adjust for some of the variation in input costs between providers, it does not adjust for differences in case volume which are particularly important to isolated, rural providers.

Summary
In this theoretical example, the isolated, rural provider meets the criteria for a structural cost difference. However, this is a simplified, hypothetical example. In reality we would expect the provider to be able to demonstrate that it is operating reasonably efficiently and it has considered alternative models of service provision in deciding how to provide services within the local health economy it serves.

4.3. Step 2: Benchmarking average costs, operational metrics and outcome measures

Providers should benchmark themselves against a suitable comparator group to demonstrate that they are reasonably efficient, given the structural issues they face. This process should include comparisons of average costs, operating metrics and outcome measures. The provider will likely need to refine the comparator group through the process to account for operational efficiency and clinical outcomes. The process should be used to help estimate a reasonably efficient cost of providing the services, given the structural issues faced by the provider. It may also help to identify opportunities for improvements in efficiency.

There are a range of publicly available data sources that commissioners and providers may use to benchmark performance. Annex 1 of this document sets out a number of useful data sources.

This subsection sets out the following processes:

- selecting a suitable comparator group
- comparing average costs
- comparing operational and quality metrics
- refining the comparator group.

4.3.1. Selecting a suitable comparator group

Effective benchmarking requires an appropriately defined comparator group. Providers should explain the basis on which they have selected their comparator group in their submissions to Monitor. They should consider the drivers of structurally higher costs when identifying an appropriate comparator group. For example, if a provider believes that service provision is uneconomic due to insufficient case volume, then we would expect its comparator group to include providers with similarly low case volumes.[26] CCG groupings (compiled by the Health and Social Care Information Centre) could be used as one way of selecting suitable comparators.

[26] The provider could use Hospital Episode Statistics (HES) data to identify providers with low case volumes. The HES database records the number of Finished Consultant Episodes (FCEs) for each provider and this could be used as a proxy for scale.

It is important to consider both the number and relevance of providers included in the comparator group, and reach an appropriate balance between both factors. Reducing the size of the group may focus on the most comparable providers, but this approach could also mean that analysis is sensitive to the cost reporting or specific circumstances of particular providers.

The following factors may be relevant when deciding on an appropriate comparator group:

- Region type (ONS super group)
- Demographics (for example, based on age profile)
- Deprivation (for example, based on Economic Deprivation Index)
- Size of trust or service (by revenue or activity)
- Service type (ie A&E with/without trauma, nurse-led, consultant-led, etc)

4.3.2. Comparing average costs

Providers should benchmark their average costs for the services covered by a local modification at both the specialty and HRG level, where it is possible to do so.[27] This analysis should demonstrate:

- whether the provider has higher average costs than the comparator group
- whether other providers in the comparator group have average costs above the nationally determined price for the service(s) in question.

Notwithstanding issues of data quality, which can be challenging when comparing different providers, this analysis could use reference costs, data from patient-level information and costing systems (PLICS) or HRG-level data from commercial benchmarking tools.[28] We encourage the use of PLICS data where possible and practical.

Benchmarking should be carried out using the latest available cost data.

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[27] We would generally expect this benchmarking to be carried out at the HRG root level.

[28] A list of useful sources for benchmarking analysis is provided in Annex 1.

An indicative table is presented below for a single HRG, using reference costs as an illustrative example. The column titled 'RCI' shows the reference cost index for each provider (for one HRG); the RCI shows each provider's cost relative to the national average (the national average cost has a value of 100).

Table 4-1: Example of average cost benchmarking

Provider	FCEs[29] (2011/12)	RCI
Provider 1 (Applicant)	50,000	135
Provider 2	45,000	122
Provider 3	57,000	153
Provider 4	51,000	142
Provider 5	53,000	128

In this example, Provider 1 is applying for a local modification as a result of its low scale and has identified a comparator group with similarly low levels of activity. The table shows that all of the providers face above-average costs for the selected HRG. The table also shows that Provider 2 has lower costs than Provider 1 despite also having lower levels of activity. This may suggest that Provider 2 is more efficient, and we would therefore expect Provider 1 to provide an explanation for the difference.

If a structural issue affects multiple HRGs within a particular department, it may be informative to group HRGs together and look at the weighted average cost for the department. Table 4-2 below illustrates how this information could be presented.

[29] Finished Consultant Episodes.

Table 4-2: Illustrative table for benchmarking average costs

	HRG 1		HRG 2		Weighted average cost across HRG 1&2
	Activity	Unit cost	Activity	Unit cost	
Provider 1					
Provider 2					
Provider 3					
Provider 4					
Provider 5					
Comparator average					
National average					

4.3.3. Comparing operational and quality metrics

In addition to comparing their average costs to the comparator group, providers should also compare operational and quality metrics. The results of cost benchmarking should be considered in the context of operational performance and clinical outcomes when establishing an efficient cost of providing a service or services.

Providers should compare operational metrics at an organisational and department level, where data is available. These metrics could be useful indicators of key cost drivers. It is important to consider both the cost and quality implications of operational metrics – for example, low staff numbers per bed may indicate a lower cost, but this staffing level may not be compliant with clinical guidelines. An illustrative table of operational metrics is presented below.

Table 4-3: Illustrative table for benchmarking operational metrics

	Provider 1	Provider 2	Provider 3
Staff turnover			
Bed occupancy			
Average length of stay – elective			
Average length of stay – non-elective			
Theatre utilisation (%)			
Agency costs as a % of total costs			
Nurses per bed			
Staff costs per bed			
Consultants per bed			
Drugs and devices cost as % of total			

Similar analysis should be prepared for quality metrics to understand how clinical outcomes and quality vary across the comparator group. This analysis will depend on the services under consideration and could be carried out in a number of different ways. We would normally expect quality benchmarking to take place at the department or specialty level. The Acute Trust Quality Dashboard gives examples of a variety of metrics that can be applied to non-specialist acute providers. Providers could also benchmark performance against national targets and relevant clinical guidelines.

A range of methods can be used to compare providers and identify particular areas of relative under or over-performance. Depending on the size and characteristics of the comparator group and the type of metric considered, it may be appropriate for providers to compare themselves to the median or mean of the group or upper or lower quartiles. The Acute Trust Quality Dashboard compares providers based on their variation from the mean (measured in standard deviations).

We would expect a provider to explain:

- how it compares to the comparator group
- the reasons any differences that are identified.

Providers should also submit a detailed explanation of potential opportunities to improve operational efficiency and clinical outcomes.[30] This will be important when determining the value of the local modification, as there may be steps that the provider could reasonably be expected to take to reduce costs; these 'avoidable' costs should not be included in the value of the proposed local modification.

4.3.4. Refining the comparator group

Providers should refine their comparator group following analysis of average costs, operating efficiency metrics and quality metrics. The comparator group should be refined to exclude inefficient providers and providers that perform poorly against quality metrics. In reality, we would expect providers to start with a relatively large comparator group and exclude providers at each stage, i.e. following analysis of costs, operating efficiency and quality. The reasons for including or excluding particular providers within the comparator group should be clearly explained.

This process should make the comparator group more relevant when trying to estimate a reasonably efficient cost for the services covered by a local modification. The refined comparator group should reflect, as far as practicable, a set of providers which face the same structural issues. Providers should then benchmark their costs against this refined comparator group.

[30] We would expect this to include an explanation of trends in operational and quality metrics over time, where data is available.

4.4. Step 3: Detailed review of provider's own costs

Providers are expected to review their own costs in detail to explain how structural issues affect their costs. Providers should explain their costs in relation to the costs of the comparator group and the nationally determined price. As noted in Subsection 4.1, we expect providers to explain cases where they have deviated from Monitor's *Approved Costing Guidance.*[31]

Providers should identify how and at what level the structural issues they face affect their costs. Providers could be uneconomic at the organisational level, or there might be specific departments, specialties or services which operate uneconomically. For example, it may be that a sub-scale provider faces structurally higher costs for a particular department because it has to employ a certain number of staff across the department to meet clinical guidelines. Other departments may not be affected in the same way. We expect providers to analyse their costs at the level at which structural issues have an impact and then consider whether there is any reason that specific HRGs would not be affected by the structural issues faced.[32]

In all cases, providers should submit:

- a breakdown of cost drivers, by cost pool (for example, direct, indirect and overhead costs)
- an explanation of internal variation in costs, for example across wards, clinicians, year-on-year and seasonal fluctuations
- an explanation and quantification of the additional costs arising from structural factors. This could for example include staff costs, where additional staff are required, or depreciation costs where fixed assets are not fully utilised
- an explanation of why the provider's costs differ from the nationally determined price and the costs of the comparator group
- an explanation and quantification of opportunities for improved efficiency.

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[31] These principles are: stakeholder agreement; consistency; data accuracy; materiality; causality and objectivity; and transparency. See Monitor's Approved Costing Guidance for further information.

[32] Local modifications apply at the individual service level (i.e. at the HRG level). However, to the extent that a group of services is affected by the same structural issue, we encourage providers to analyse costs at this level.

When submitting this information, we would expect providers to show that existing service delivery models are in line with clinical best practice, for example, by reference to relevant clinical guidelines (such as National Institute for Health and Care Excellence and Royal College guidelines).

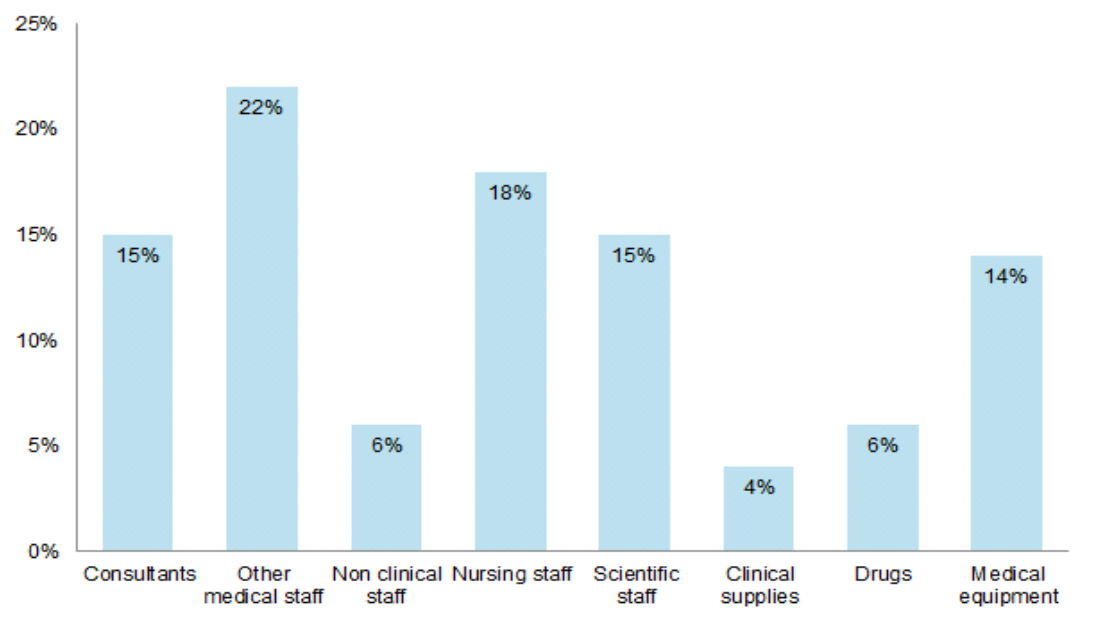
An illustrative example of a rural provider that faces scale issues is presented below.

Example 4-2: Analysis of cost drivers

Consider a rural provider of Type 1, 24/7 A&E services, with low case volumes.

The provider would have to submit a detailed narrative to explain the factors driving its higher costs. This provider might identify direct costs as the key reason for its higher average costs and breakdown those costs into specific cost drivers.

Example 4-2: Illustrative breakdown of direct costs for A&E services



In this particular example, staff costs are the largest component of direct costs. We would expect the provider to explain why this is the case. In our example of a rural provider of Type 1 A&E services, high staff costs could be driven by the mandatory staffing requirements that are associated with a Type 1 A&E service. This could also affect other services, for example, maternity services where there are also minimum staffing requirements.

Providers could also break down total costs into fixed costs, semi-fixed costs and variable costs in order to explain how particular issues affect their cost base. For example, the high fixed costs associated with certain services could affect the viability of providing these services for a provider with low case volumes. The cost breakdown should identify the structural issues faced by a provider.

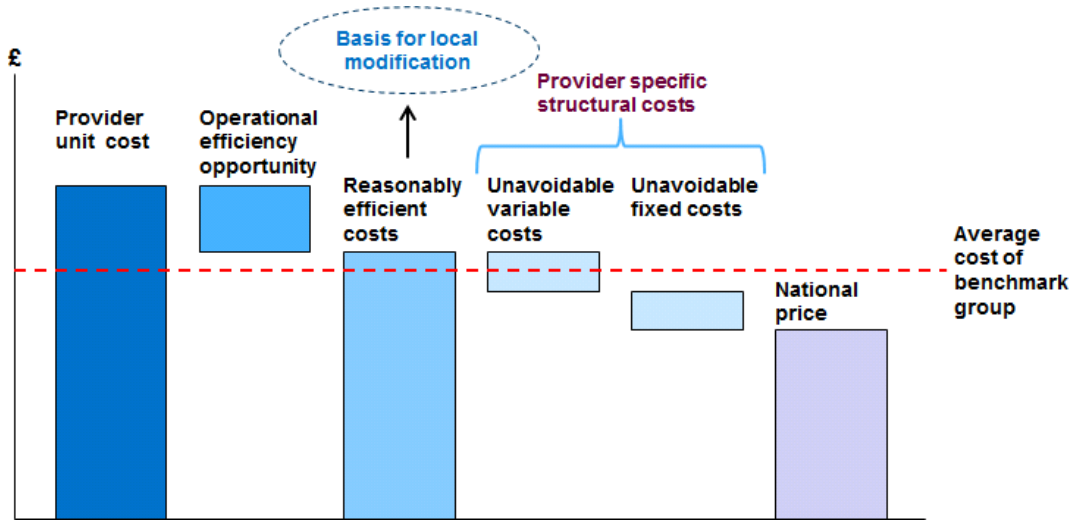
Where possible, providers should submit details of internal variation in costs, including variation across wards, clinicians and over time.

4.5. Step 4: Determine efficient cost based on benchmark cost and provider's review of its own costs

A local modification can be used to increase the nationally determined price for a particular service or group of services. When submitting a local modification to Monitor, commissioners and providers (or providers in the case of an application) must propose an increase to the nationally determined price which reflects the efficient cost of providing the service(s). This may not be the actual cost the provider incurs in the provision of the service as it might be the case that some of the additional cost incurred by the provider arises from inefficiency rather than structural issues. The efficient cost should be based on expected activity levels, given the structural issues faced by a provider.

Based on the nationally determined price, cost benchmarking and a review of the provider's own costs, we expect providers to determine and explain the reasonably efficient cost of providing the services that would be covered by the local modification and therefore the value of the proposed local modification. The reasonably efficient cost may be greater or less than the average cost of the benchmark group, depending on the structural issues faced by the provider in question. Figure 4-2 below summarises the components of an illustrative provider's costs and the basis on which the value of a local modification should be calculated.

Figure 4-2: Basis for calculating value of proposed local modification



As shown in this diagram, in determining the value of the local modification, providers should take account of the potential for them to improve operational efficiency. Providers facing structurally higher costs may still reasonably be expected to take certain steps to improve efficiency, whilst maintaining clinical outcomes and quality of care. For example, providers should engage with commissioners and clinicians to ensure that services are being delivered in the most appropriate way, in line with clinical best practice. Similarly, providers should submit evidence of clinical support for the current configuration of the affected service.

Commissioners and providers should submit a supportive narrative to explain how the proposed local modification value has been determined.

4.6. Step 5: Determine structure of the local modification

Once a commissioner and provider (or a provider only, in the case of local modification applications) have decided the value of the proposed local modification, they must then determine the structure of the modification.

The proposed modification must apply to each of the services specified, and the level or structure of the modification may be different for each service.

As noted above and outlined in the *2016/17 National Tariff Payment System*, a local modification can be used to increase the nationally determined price for a particular service or group of services. In many cases local modifications may be applied as a uniform uplift to the unit price. For example, a 25% uplift at all levels of activity. However, it is also possible to propose a modification that is contingent on the volume of activity. For example, a provider and commissioner could agree to a higher modification at low volumes of activity, to take into account fixed costs associated with providing certain services.

Consider the example again of a rural provider with low case volumes. For a particular HRG, this provider provides 4,000 units of activity per year, compared with the national average of 7,000 units of activity. The nationally determined price (i.e., after national variations) for this HRG is £1,000 per unit, which means the provider would normally be paid £4.0 million for providing the service. After applying Monitor's proposed method, the provider and commissioner agree that the provider is unable to cover the fixed costs of providing the service due to its low case volumes. The provider faces total costs of £5.0 million for 4,000 units of activity, and its shortfall on fixed costs is estimated to be £1.0 million in total.

In this case, the provider and commissioner could structure the local modification so that the nationally determined price is increased by £250 to £1,250 for each unit of activity between 1 and 4,000 (the expected annual level of activity) and maintained at £1,000 for all units above 4,000. In this simplified example, the commissioner and provider may wish to agree an exceptional clause to account for the possibility that the provider's actual activity levels significantly exceed projections.

5. Submitting a local modification agreement or application

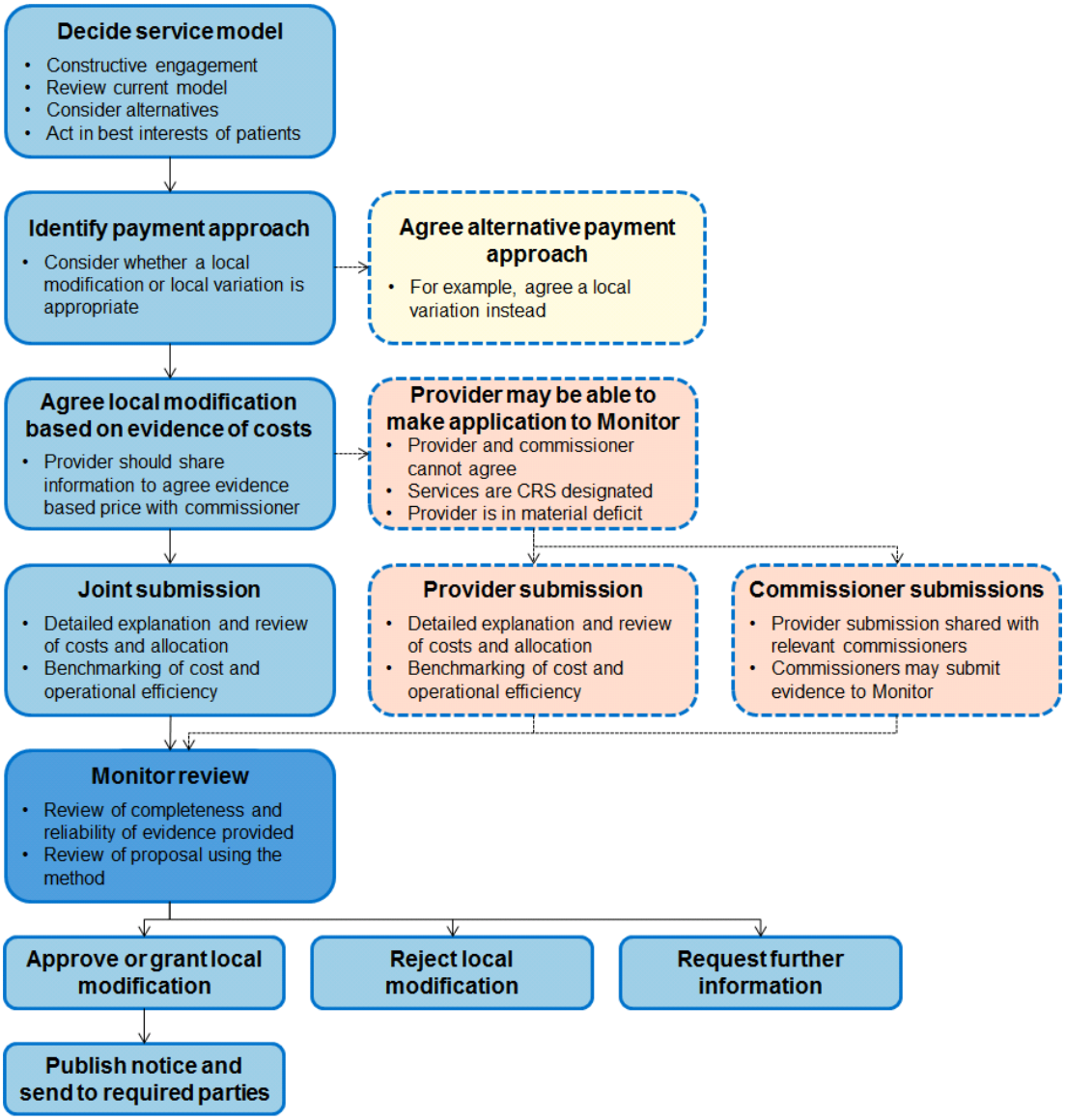
For a local modification to be approved by Monitor, commissioners and providers (or just providers in the case of applications) must undertake the analysis described in Section 4 and then submit a completed local modifications template (details of which are provided below) along with supporting evidence and narrative via Monitor's Pricing Portal. The template and a worked example can be downloaded from the Pricing Portal.

When submitting a local modification to Monitor, the relevant officer at the provider must state their full name and position and include a written declaration (either in the email sent to Monitor, or attached as a separate document). The declaration must state that:

- the officer is authorised to submit the local modification on behalf of the provider identified within it
- the submission accurately sets out the circumstances of the provider and the provider's requested local modification.

The process for submitting a local modification is summarised in Figure 5-1 below.

Figure 5-1: Overview of process for local modifications



As illustrated in Figure 5-1 above, our process for local modifications requires commissioners and providers to engage constructively with each other to review the current model of service provision, consider alternatives, and decide on a delivery model that is in the best interests of patients. After the service model has been chosen, the provider and commissioner must identify the appropriate payment approach and, in the case of a local modification, agree a modification to the nationally determined price. Throughout this process, the commissioner and provider must apply the principles set out in Section 6 of the *2016/17 National Tariff Payment System*. They must then submit evidence to Monitor to demonstrate that their proposed modification is appropriate based on the method set out in Section 6 of the *2016/17 National Tariff Payment System*.

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

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

This section describes the following:

- **Local modification template**: the information that is requested in the template and the way these should be populated by commissioners and providers.
- **Supporting evidence**: the additional evidence and information that commissioners and providers would be expected to provide when submitting a local modification to Monitor for approval.
- **Additional evidence required for applications**: the additional information that we would expect providers to submit in the case of a local modification application (where the local modification has not been agreed by the commissioner).
- **Process for publication**: our process for publishing summary templates for local modifications.

5.2. Local modification template

NHS England and Monitor have developed a local modifications template for commissioners and providers (providers only in the case of a local modification application)[33] to use when recording and then submitting a proposed local modification to Monitor. The completed template should be submitted with the supporting evidence described in Section 4 above, and a self-certification letter confirming the accuracy of that information, including any additional terms of the proposed local modification which are not included in the template.

The local modifications template and a worked example can be downloaded from Monitor's Pricing Portal. The template includes detailed instructions on how to fill in each field. Answers should be clear, concise and submitted with evidence where required.

The template contains the information that Monitor will publish for all approved local modifications and therefore should not include any information identifying individual patients. In addition, it should not include information which is confidential to third parties, unless consent has been obtained. It is divided into five sections, which require the commissioner and provider to set out the following information:

- **Background information** – services covered by the local modification and the commissioner and provider to which it would apply.
- **Service delivery model** – how the services are to be provided to the patients, as well as the current costs and revenue of the services covered by the proposed local modification. (**Note:** Local modifications apply to national prices after any applicable national variations.)
- **Local modification details** – the price proposed under the local modification and the associated incremental annual revenue.
- **Additional considerations** – details of the expected impact on patients and the wider health care economy.
- **Contact details** – for queries about this local modification.

[33] In the explanation of summary templates, we refer to information to be submitted by providers and commissioners. However, in the case of a local modification application, we would expect **providers alone** to submit all of this information. In the case of an application, relevant commissioners will be given the opportunity to provide their own submissions.

5.3. Applications

As set out in Section 6 of the *2016/17 National Tariff Payment System*, providers must satisfy three additional conditions in order to be eligible to submit a local modification application. A provider applying for a local modification must:

- demonstrate that it has engaged constructively with its commissioners to try to agree alternative means of providing the services at the nationally determined price and, if unsuccessful, a local modification agreement
- demonstrate that the services are Commissioner Requested Services (CRS)[34] or, in the case of NHS trusts or other providers who are not licensed, the provider cannot reasonably cease to provide the services
- demonstrate that it has a deficit equal to or greater than 4% of revenues at an organisation level in the previous financial year (i.e. 2013/14 for the 2016/17 national tariff).[35]

Providers must submit evidence to show that each of these three conditions has been met.

5.4. Supporting evidence

In addition to the summary template described above, commissioners and providers must also submit supporting evidence to Monitor for local modifications.[36] This information should be clearly explained, based on evidence, and supported by narrative, where appropriate. As explained in Section 4 above, commissioners and providers should submit supporting evidence in the following three areas:

- identifying that average costs are above the nationally determined price for a service or group of services
- benchmarking average costs, operational metrics and quality outcomes against a suitable comparator set

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[34] See: *Guidance for commissioners on ensuring the continuity of health care services; Designating Commissioner Requested Services and Location Specific Services*, 28 March 2013.

[35] We will consider deficits before impairments and gain/loss on transfer by absorption. Annex 2 of this document provides further details on the adjusted deficit to be considered by Monitor when assessing local modification applications.

[36] Sections 124(4) and 125(2) of the 2012 Act provide that agreements and applications must be supported by such evidence as Monitor may require.

- internal review of costs to justify the structurally higher costs and basis for the proposed local modification.

Commissioners and providers must also clearly explain the sources of any data provided and the reliability of the data. For example, details of whether data has been subject to any validation processes should be provided.

Supporting evidence should not include any information identifying individual patients. In addition, it should not include any information which is confidential to third parties, unless consent has been obtained. Any information that is commercially sensitive should be clearly identified to assist Monitor in the event of a freedom of information request.

5.5. Process for publication

Promoting transparency is one of the three principles that apply to all local variations, modifications and prices (see Subsection 1.1). As required by the 2012 Act, and in line with our aim to increase transparency, Monitor will publish key information on all local modifications agreements and applications that are approved.[37]

[37] Monitor is required to send a notice to the Secretary of State and such CCGs, providers and other persons as it considers appropriate, which states the modification and the date it takes effect. This notice must be published. See sections 124(6) to (8) and 125(6) to (8).

5.6. Submitting local price information

For many NHS services, there are no national prices. Some of these services have nationally specified currencies, but others do not. In both cases, commissioners and providers must work together to set prices for these services. The 2012 Act allows NHS England and Monitor to set rules for local price-setting for such services.[38] Section 6 of the *2016/17 National Tariff Payment System* sets out the rules for local price-setting.

The following rules apply for all local prices:

- Commissioners and providers must apply the principles set out in Section 6 of the *2016/17 National Tariff Payment System* when agreeing local prices. This means local prices must:
    - be in the best interest of patients
    - promote transparency, accountability and sharing of best practice
    - providers and commissioners must engage constructively.
- Commissioners and providers should have regard to the national tariff efficiency and cost uplift factors for 2016/17[39] when setting local prices for services without a national price for 2016/17 if those services had locally agreed prices in 2015/16.
- For services with national currencies (but no national prices), providers must submit details of agreed local prices to Monitor using the local prices template, or complete and submit a local variation template if they agree with their commissioner not to use the nationally specified currencies. The templates and a worked example of the local variation template can be downloaded from Monitor's Pricing Portal.

For services without a national currency, commissioners and providers do not have to submit information to Monitor; however, where there **are** national currencies we require information to be submitted to us.

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[38] 2012 Act, sections116(4)(b) and 118(5)(b).
[39] Set out in Section 5 of this document.

The services with national currencies but without national prices covered by this reporting requirement are:

- Working age and older people mental health services
- Ambulance services
- Specialist rehabilitation
- Critical care - adult and neonatal
- HIV adult outpatient services
- Renal transplantation
- Positron emission tomography and computerised tomography (PET/CT)
- Cochlear implants
- Transcatheter Aortic Valve Implantation (TAVI)
- Complex therapeutic endoscopy
- Dialysis for acute kidney injury.

The process for submitting information to Monitor depends on whether or not the national currency is used.

5.7. Local prices using national currencies

At present, there is limited transparency regarding agreed local prices for services with no national price. To help inform price-setting in the future, providers must submit details of agreed unit prices for services that have national currencies but do not have national prices (see Rule 3 in Section 6 of the *2016/17 National Tariff Payment System*).

The provider should submit details of agreed local prices using national currencies to Monitor by completing the local prices template and send this to Monitor using the Pricing Portal.

When submitting a local prices template to Monitor, the relevant officer at the provider must state their full name and position and include a written declaration (either included in the email sent to Monitor or attached as a separate document). The declaration must state that:

- the named officer is authorised to submit the local prices template on behalf of the provider identified within it
- the template accurately sets out the prices agreed by the provider.

Local price information using national currencies and relating to 2016/17 must be submitted to Monitor on or before **30 June 2016**.

5.8. Local prices moving away from national currencies

There may be cases where a national currency is specified for a service, but the commissioner and provider of that service wish to move away from using the national currency. If so, the commissioner and provider may agree a price without using the national currency, as long as:

- the agreement is documented in the commissioning contract between the commissioner and provider which covers the service in question
- the commissioner maintains and publishes a written statement of the agreement, using the template provided by Monitor, within 30 days of the agreement
- the commissioner has regard to the guidance in Section 6 of the *2016/17 National Tariff Payment System* when preparing and updating the written statement
- the commissioner submits the written statement to Monitor by completing the local variations template and sending this to Monitor using the Pricing Portal.

When submitting a local variations template to Monitor, the relevant commissioning officer must state their full name and position and include a written declaration (either included in the email sent to Monitor or attached as a separate document). The declaration must state that:

- the named officer is authorised to submit the local variations template on behalf of the commissioners identified within it
- the template accurately sets out the variation agreed by those commissioners.

Local prices that move away from national currencies will be published on our website.

Annex 1: Useful sources for benchmarking analysis

This annex sets out benchmarking tools and data sources that could be used by commissioners and providers when preparing a local modification submission.

Table A1-1: Benchmarking tools

Source	Link and brief description	Suitable organisations
NHS Comparators	www.nhscomparators.nhs.uk/NHSComparators/Login.aspx NHS Comparators is designed to help NHS organisations improve the quality of care delivered by comparing activity and costs on a local, regional and national level. This includes activity and cost data from the Secondary Uses Service (SUS), along with data from the quality and outcomes framework (QOF), GP practice demographic population profile data and prescribing data.	Commissioners, acute trusts, mental health providers

Table A1-2: Data sources

Source	Link and brief description	Suitable organisations
Annual accounts	Audited annual accounts provide data on provider financial performance at the organisation level.	All NHS providers
The Health and Social Care Information Centre	www.hscic.gov.uk/home The Health and Social Care Information Centre is a data, information and technology resource for the health and care system, bringing together data from multiple sources.	All NHS organisations
Hospital Episode Statistics Data	www.hscic.gov.uk/hes HES is a data warehouse containing details of all admissions, outpatient attendances and A&E attendances. HES data is now provided by HSCIC.	Commissioners, acute trusts, mental health providers
Secondary Uses Service Data	www.hscic.gov.uk/sus SUS is the single, comprehensive repository for health care data which enables a range of reporting and analyses to support the NHS in the delivery of health care services.	Any health care provider who submits data to SUS
NHS Evidence	https://www.evidence.nhs.uk/ Online search facility that enables users to locate the most appropriate information by sifting the best and most relevant search results. NHS Athens access is needed.	Suitable for all NHS organisations
Reference Costs	Reference Costs record the unit costs of providing NHS services with national currencies. The DH has collected reference costs from NHS providers for every financial year since 1997/98.	Acute, mental health and ambulance providers

Annex 2: Provider deficit condition for local modification applications

To comply with our method for local modification applications, a provider must demonstrate that it has a deficit equal to or greater than 4% of revenues at an organisation level in 2015/16 for the 2016/17 national tariff (for an application for local modifications in 2017/18). This requirement does not apply to local modification agreements.

In this annex, we set out how our method requires that providers calculate their deficit.

We use a measure of the deficit before impairments and the gain/loss on transfers by absorption. This measure of the deficit is intended to reflect the underlying performance of the organisation by removing transitory shocks to revenue which are not related to the ongoing delivery of services.

Technical definition of deficit

Table A2-1 shows the formula to be used in order to calculate the 'adjusted' provider deficit that Monitor will consider when assessing local modification applications.

Table A2-1: Components of 'adjusted' deficit calculation

Account Component		Calculation
Surplus/deficit after tax		+
Gain/loss on transfers by absorption		-
Total impairment losses/reversals		-
Adjusted provider deficit		

The components of the 'adjusted' deficit calculation are explained below in the context of NHS foundation trusts and NHS trusts, given the differences in reporting systems between the two types of organisation.

We would expect providers submitting applications to inform us of any one-off costs or revenue which would have a material impact on their deficit that are not included in the 'adjusted deficit' calculation above.

NHS foundation trusts

Providers should submit audited financial information if it is available at the time of submitting the local modification application. We would expect NHS foundation trusts to calculate their deficit using Foundation Trust Consolidation (FTC) form data. Table A2-2 below shows the references from the FTC form for the relevant data required to calculate the 'adjusted' deficit.

Table A2-2: Calculation of adjusted deficit based on FTC template

Account Component		FTC Form Reference	
		Sheet	Code (*maincode/subcode*)
Surplus/deficit for the year		4. CF	01A/160
Gain/loss on transfers by absorption		14. PPE	14A/117
Total impairment losses/reversals			
	PFI	14. PPE	14BD/100
	Non-PFI	14. PPE	14BA/100 - 14BD/100

If audited data is not available at the time of submitting a local modification application, we would expect providers to calculate their deficit based on Annual Plan Review (APR) data. Table A2-3 below shows the references from the APR form for the relevant data required to calculated the 'adjusted deficit'.

Table A2-3: Calculation of adjusted deficit based on APR template

Account Component		APR Form Reference
		Code
Total comprehensive surplus/deficit		IS09500
Gain/loss on transfers by absorption		IS03650
Total impairment losses/reversals		
	PFI	IS04510
	Non-PFI	IS04500

NHS trusts

We expect NHS trusts to calculate their deficit using Financial Information System (FIMS) data. Table A2-4 below shows the references from the FIMS form for the relevant data required to calculate the 'adjusted' deficit.

Table A2-4: Calculation of adjusted deficit based on FIMS template

Account Component	FIMS Form Reference	
	Sheet	Code (*maincode/subcode*)
Overall surplus/deficit	TRU01	01/180
Gain/loss on transfers by absorption	TRU01	01/195
Total impairment losses/reversals, net	TRU06	01/260:300

If audited data is not available at the time of submitting a local modification application, we would expect providers to calculate their 'adjusted' deficit based on unaudited planning data.

Revenue

Providers should express their deficits as a percentage of total revenue. Table A2-5 below shows the references for total revenue across various provider financial templates.

Table A2-5: Template references for total revenue

Template	Reference	
	Sheet	Code
FTC	SoCI	01A/245
APR		IS01000, IS04000
FIMS	TRU1	01/120, 01/130, 01/150