

# **2017/18 and 2018/19 National Tariff Payment System**

**NHS England and NHS Improvement**

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## 1. Introduction

1. This document is the national tariff, specifying the currencies, national prices, the method for determining those prices, the local pricing and payment rules, the methods for determining local modifications and related guidance that make up the national tariff payment system for 2017 to 2019 (the 2017/19 NTPS).
2. Since 1 April 2016, Monitor and the NHS Trust Development Authority have been operating as a single integrated organisation known as NHS Improvement. This document is however published in exercise of functions conferred on Monitor by section 116 of the Health and Social Care Act 2012. In this document, 'NHS Improvement' means Monitor, unless the context otherwise requires.
3. This 2017/19 NTPS has effect for the period beginning on 1 April 2017 and ending on 31 March 2019 or the day before the next national tariff published under Section 116 of the 2012 Act has effect, whichever is the later.<sup>1</sup>
4. National prices published for the 2017/18 financial year will have effect from 1 April 2017. National prices published for the 2018/19 financial year will have effect from 1 April 2018.
5. The document is split into six sections and six annexes. The six sections are:
  - a. the scope of the tariff
  - b. the currencies used to set national prices
  - c. the method for determining national prices
  - d. national variations to national prices
  - e. locally determined prices
  - f. payment rules.

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<sup>1</sup> If a replacement national tariff was to be introduced before the end of the two-year period, this tariff would cease to have effect when that new tariff takes effect.

**Table 1: 2017/19 NTPS annexes**

Annex	Description
A	The national prices and the national tariff workbook
B	The model used to set national prices
C	Technical guidance for mental health clusters
D	Guidance on currencies with national prices
E	Guidance on currencies with no national price
F	Guidance on best practice tariffs

6. The national tariff is also supported by documents containing guidance and other information.

**Table 2: Supporting guidance to the 2017/19 NTPS**

Title
A guide to the market forces factor
Guidance for commissioners on the marginal rate emergency rule and the 30-day readmission rule
Non-mandatory prices
Innovation and technology tariff

## 2. Scope of the 2017/19 NTPS

7. The scope of services covered by the 2017/19 NTPS is the same as that under the 2016/17 NTPS.
8. As set out in the [Health and Social Care Act 2012](#),<sup>2</sup> the national tariff covers the pricing of healthcare services provided for the purposes of the NHS. Subject to what we explain below, this covers all forms of NHS healthcare provided to individuals, whether relating to physical or mental health and whether commissioned by clinical commissioning groups (CCGs), NHS England or local authorities acting on behalf of NHS commissioners under partnership arrangements.
9. Various healthcare services are, however, outside the scope of the national tariff, as explained below.

### 2.1. Public health services

10. The national tariff does not apply to public health services:<sup>3</sup>
  - a. provided or commissioned by local authorities or Public Health England
  - b. commissioned by NHS England under its Section 7A public health functions agreement with the Secretary of State.<sup>4</sup>
11. Public health services commissioned by local authorities include local open access sexual health services and universal health visitor reviews. The services commissioned by NHS England under Section 7A arrangements include public health screening programmes, sexual assault services and public health services for people in prisons.

### 2.2. Primary care services

12. The 2017/19 NTPS does not apply to primary care services (general practice, community pharmacy, dental practice and community optometry) where payment is substantively determined by or in accordance with regulations or directions, and related instruments, made under the provisions of the National Health Service Act 2006 ('the 2006 Act').<sup>5</sup>
13. Where the payment for NHS services provided in a primary care setting is not determined by or in accordance with regulations or directions, or related

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<sup>2</sup> [www.legislation.gov.uk/ukpga/2012/7/contents/enacted](http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted)

<sup>3</sup> See the meaning of 'healthcare service' given in section 64 of the 2012 Act; and the exclusion of public health services in section 116(11).

<sup>4</sup> For the Section 7A agreement, see: [Public Health Commissioning in the NHS 2016 to 2017](#).

<sup>5</sup> 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.

instruments, made under the 2006 Act then the 2017/19 NTPS rules on local price setting apply. For instance, local price-setting rules apply to minor surgical procedures performed by GPs and commissioned by clinical commissioning groups (CCGs). The rules governing payments for these services are set out in Section 6 Locally determined prices.

### **2.3. Personal health budgets**

14. A personal health budget (PHB) is an amount of money to support the identified health and wellbeing needs of a particular patient, planned and agreed between that patient and their local NHS.
15. There are three types of PHB:
  - a. Notional budget: no money changes hands – the patient and their NHS commissioner agree how to spend the money. The NHS will then arrange the agreed care.
  - b. Real budget held by a third party: an organisation legally independent of the patient and their NHS commissioner will hold the budget and pay for the care in the agreed care plan.
  - c. Direct payment for healthcare: the budget is transferred to the patient to buy the care that has been agreed between the patient and their NHS commissioner.
16. Payment to providers of NHS services from a notional budget is in the scope of the 2017/19 NTPS. It will either be governed by national prices as set out in Annex A (including national variations set out in Section 5) or subject to the local pricing rules (see Section 6.4).
17. 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 2017/19 NTPS does not apply.
18. If a PHB takes the form of a direct payment to the patient or third-party budget, the payments for health and care services agreed in the care plan and funded from the direct payment are not in the scope of the 2017/19 NTPS. Direct payments for healthcare are governed by regulations made under sections 12A(4) and 12B(1) to (4) of the 2006 Act.<sup>6</sup>

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<sup>6</sup> See the National Health Service (Direct Payments) Regulations 2013 (SI 2013/1617, as amended) <http://www.legislation.gov.uk/ukxi/2013/1617/contents/made>

19. The following are not in the scope of the 2017/19 NTPS, as they do not involve paying for provision of healthcare services:
- a. payment for assessing an individual's needs to determine a PHB
  - b. payment for advocacy: advice to individuals and their carers about how to use their PHB
  - c. payment for the use of a third party to manage an individual's PHB on their behalf.
20. More information about implementing PHBs can be found on the [NHS Personal Health Budgets page](#).<sup>7</sup>

#### **2.4. Integrated health and social care**

21. Section 75 of the 2006 Act provides 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.
22. Where NHS healthcare services are commissioned under these arrangements ('joint commissioning'), they remain in the scope of the 2017/19 NTPS even if commissioned by a local authority.
23. Payment to providers of NHS services that are jointly commissioned are governed either by a national price as set out in Annex A (including national variations set out in Section 5) where applicable, or by a local price (including a local variation in Section 6.2).
24. Local authority social care or public health services commissioned under joint commissioning arrangements are outside the scope of the 2017/19 NTPS.

#### **2.5. Contractual incentives and sanctions**

25. Commissioners' application of Commissioning for Quality and Innovation (CQUIN) payments and contractual sanctions are based on provider performance, after a provider's income has been determined in accordance with the 2017/19 NTPS. If a contractual sanction changes the amount paid for the provision of an NHS service, this is permitted under the rules relating to the making of payments to providers under Section 7.

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<sup>7</sup> <http://www.england.nhs.uk/healthbudgets/>

## 2.6. Devolved administrations

26. The pricing provisions of the 2012 Act cover healthcare services in the NHS in England only. The devolved administrations (DAs) are responsible for the NHS in Scotland, Wales and Northern Ireland. If a patient from Scotland, Wales or Northern Ireland is treated in England or vice versa, the 2017/19 NTPS applies in some but not all circumstances.
27. Table 3 summarises how the 2017/19 NTPS applies to various cross-border scenarios. 'DA commissioner' or 'DA provider' refers to a commissioner or provider in Scotland, Wales and Northern Ireland.

**Table 3: How the 2017/19 NTPS applies to devolved administrations**

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

28. In the final scenario above, the commissioner in England has to follow the prices and rules in the 2017/19 NTPS, but there is no such requirement for the DA provider. The commissioner in England may wish or need to pay a price set locally in the country in question, or use a different currency from that mandated by the national tariff. In such cases, the commissioner must follow the rules for local pricing (see Section 6). If there is a national price for the service, a local variation would be required to pay a different price to the DA provider or to make a change to the currency. If there is no national price, the commissioner should follow the rules for local price setting.



29. 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](#)<sup>8</sup> 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](#).<sup>9</sup> The scope of the 2017/19 NTPS does not cover payment responsibility rules as set out in these documents. These rules should therefore be applied as well as any applicable provisions of the 2017/19 NTPS.

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<sup>8</sup> [www.england.nhs.uk/wp-content/uploads/2013/03/england-wales-protocol.pdf](http://www.england.nhs.uk/wp-content/uploads/2013/03/england-wales-protocol.pdf)

<sup>9</sup> This guidance is set out in [Who Pays? Determining responsibility for payments to providers](#), [www.england.nhs.uk/wp-content/uploads/2014/05/who-pays.pdf](http://www.england.nhs.uk/wp-content/uploads/2014/05/who-pays.pdf)

### 3. Currencies with national prices

30. Currencies are one of the 'building blocks' that support the NTPS. They include the clinical grouping classification systems for which there are national prices in 2016/17.
31. 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.<sup>10</sup> The healthcare services to be specified must be agreed between NHS England and NHS Improvement.<sup>11</sup> The 2012 Act also provides that the national tariff may include rules for determining which currency applies where there is more than one currency and price for the same service.
32. We are using healthcare resource group HRG4+ currency design as the basis for setting national prices for admitted patient care, outpatient procedures and accident and emergency (A&E) attendances. We are using 'phase 3' of the currency design, which was used for the collection of the 2014/15 reference costs.<sup>12</sup>
33. This section should be read with the following information set out in:
  - a. Annex A: National tariff workbook. This contains:
    - i. the list of national prices (and related currencies)
    - ii. maternity data requirements and definitions
    - iii. the lists of high cost drugs and devices
  - b. Annex D: Guidance on currencies with national prices
  - c. Annex F: Guidance on best practice tariffs.

#### 3.1. Classification, grouping and currency

34. The NHS payment system relies on patient-level data. To operate effectively, the payment system needs:
  - a. a way of capturing and classifying clinical activity: this enables information about patient diagnoses and healthcare interventions to be captured in a standard format
  - b. a currency: the large number of codes for admitted patient activity in the primary classification system makes it impractical as a basis for payment;

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<sup>10</sup> 2012 Act, Section 116(1)(a)

<sup>11</sup> 2012 Act, Section 118(7)

<sup>12</sup> Details available at <http://digital.nhs.uk/article/6226/HRG4-201415-Reference-Cost-Grouper>

instead casemix groupings are used as the currency for admitted patients, outpatient procedures and A&E. For outpatient attendances, the currency is based on groupings that relate to clinic attendance and categories.

35. Clinical classification systems describe information from patient records with standardised definitions and nomenclature. The 2017/19 NTPS relies largely on two standard classifications to record clinical data for admitted patients. These are:
  - a. the World Health Organization International Classification of Diseases, 10th revision (ICD-10) for diagnoses<sup>13</sup>
  - b. Office of Population Censuses and Surveys 4 (OPCS-4) for operations, procedures and interventions.<sup>14</sup>
36. 'Grouping' is the process of using clinical information such as diagnosis codes (in admitted patient care only), procedure codes (in admitted patient care and outpatient care), treatment codes (A&E only) and investigation codes (A&E only) to classify patients to casemix groups structured around healthcare resource groups. HRGs are groupings of clinically similar conditions or treatments that use similar levels of healthcare resources. The grouping is done using grouper software produced by NHS Digital.<sup>15</sup> NHS Digital<sup>16</sup> also publishes comprehensive documentation giving the logic and process behind the software's derivation of HRGs as well as other materials that explain and support the development of the currencies that underpin the national tariff.<sup>17</sup>
37. A 'currency' is a unit of healthcare for which a payment is made. Under the 2012 Act, a healthcare service for which a national price is payable must be specified in the national tariff. A currency can take one of several forms. We use spell-based HRGs as the currency for admitted patient care and some outpatient procedures. The currencies for A&E services are based on A&E attendances.
38. The HRG currency design used for the 2017/19 NTPS is known as HRG4+ and is arranged into chapters, each covering a body system. Some chapters are divided into subchapters. The specific design for the 2017/19 NTPS is that used to collect 2014/15 reference costs.
39. The currency used for outpatient attendances is based on attendance type and clinic type, defined by treatment function code (TFC). This is explained in more detail in Section 3.2.4.

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<sup>13</sup> The 5th edition update of ICD-10 was published in April 2015.

<sup>14</sup> OPCS version 4.8 has been incorporated into the currency design used for national prices.

<sup>15</sup> <http://digital.nhs.uk/casemix/payment>

<sup>16</sup> Any enquiries on the 'Code to grouper' software, guidance and confirmation of appropriate coding and the grouping of activities can be sent to [enquiries@nhsdigital.nhs.uk](mailto:enquiries@nhsdigital.nhs.uk)

<sup>17</sup> <http://digital.nhs.uk/casemix/payment>

## 3.2. Currencies for which there are national prices

- 40. Section 3.2.1 describes the admitted patient care currencies for which there are national prices.
- 41. Details of the methods we use to determine the national prices are provided in Section 4. The list of national prices and related currencies is in Annex A.
- 42. In particular circumstances we specify services in different ways, and attach different prices; for example, setting best practice tariffs (BPTs) to incentivise improved outcomes for particular cohorts of patients. As well as specifying the currencies, Section 3 (in combination with Annexes A, D and F) includes the rules for determining which currencies and prices apply where a service is specified in more than one way.
- 43. The rules for the local pricing of services with mandatory currencies but no national prices – such as adult mental health and ambulance services – are set out in Section 6.4.

### 3.2.1. Admitted patient care

- 44. Spell-based HRG4+ is the currency design for admitted patient care covering the period from admission to discharge. If a patient is under the care of one consultant for their entire spell,<sup>18</sup> this would comprise one finished consultant episode (FCE). Occasionally, a patient will be under the care of more than one consultant during their spell; this would mean that the spell had multiple FCEs.
- 45. 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.
- 46. The costs of some elements of the care pathway, such as critical care and high cost drugs, are excluded from national prices. These costs are paid under the rules applicable to local pricing.
- 47. To promote movement to day-case settings where appropriate, most elective prices are for the average of day-case and ordinary elective-case costs, weighted according to the proportion of activity in each group.
- 48. For a few HRGs there is a single price across outpatient procedures and day cases, or a single price across all settings. This approach has been taken where a price that is independent of setting is clinically appropriate.

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<sup>18</sup> A spell is a period from admission to discharge or death. A spell starts following the decision to admit the patient.

49. When a patient has more than one distinct admission on the same day<sup>19</sup> (eg the patient is admitted in the morning, discharged, then re-admitted in the afternoon), each admission is counted as the beginning of a separate spell, although a short stay adjustment may apply to the first admission.
50. Short stay emergency adjustments<sup>20</sup> and long stay payments<sup>21</sup> apply to admitted patient care. These are explained in detail below.

*Changes to the scope of services with national prices*

51. The services for which there are national prices remain the same for 2017/19 as for 2016/17, except that we are adding the following services :
- a. cochlear implants (CA41Z, CA42Z)
  - b. complex computerised tomography scans (RD28Z)
  - c. complex therapeutic endoscopic, upper or lower gastrointestinal procedures (FZ89Z)
  - d. photodynamic therapy (JC46Z, JC47A and JC47B).
52. While the tariff has been informed by the 2014/15 design of HRG4+ and the 2014/15 reference cost relativities, the scope of the tariff, unless explicitly stated otherwise, is consistent with 2016/17.
53. Following feedback from the sector it was clear that certain technical issues were not obvious. To clarify:
- a. Annex A (tab 8: Service clarification) provides that cancer multidisciplinary team (MDT) services do not have a national price. This covers colorectal, local gynaecological, specialist gynaecological, breast, specialist upper gastrointestinal teams and other cancer MDT services.
  - b. Annex A (tab 13a: HC devices) provides that soft tissue sarcoma procedures do not have a national price. These include an ICD10 (any position) diagnosis of C40, C41, C47, C48, C49 or C79.5, and OPCS primary procedure code is not missing and is not a chapter X code, for example W052 (implantation massive endoprosthesis replacement of bone).

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<sup>19</sup> Calendar day not 24-hour period.

<sup>20</sup> 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 paid for.

<sup>21</sup> For patients who remain in hospital beyond an expected length of stay for clinical reasons, there is an additional reimbursement to the national price called a 'long stay payment' (sometimes referred to as an 'excess bed day payment'). The long stay payment applies at a daily rate to all HRGs where the length of stay of the spell exceeds a 'trim point' specific to the HRG.

### *Short stay emergency adjustment*

54. The short stay emergency adjustment (SSEM) is a mechanism for ensuring appropriate payment for lengths of stay shorter than two days, where the average HRG length of stay (LoS) is longer. It applies whether the patient is admitted under a medical or a surgical specialty providing all the following criteria are met:
- a. the patient's adjusted LoS is either zero or one day
  - b. the patient is not a child, defined as aged under 19 years on the date of admission
  - c. the admission method code is 21-25, 2A, 2B, 2C or 2D (or 28 if the provider has not implemented Commissioning Data Set CDS version 6.2)
  - d. the average length of non-elective stay for the HRG is two or more days
  - e. the assignment of the HRG can be based on a diagnosis code, rather than on a procedure code alone, irrespective of whether a diagnosis or procedure is dominant in the HRG derivation.
55. The adjustment percentages applied are set out in Table 4.

**Table 4: HRG short stay emergency adjustment percentages**

HRG Average length of stay	2017/19 short stay percentages
< 2 days	100.0
2 days	75.0
3 or 4 days	50.0
≥5 days	30.0

56. For BPTs the short stay emergency adjustment is not universally applicable as:
- a. SSEM only applies to diagnostic driven HRGs
  - b. it does not apply, for example, when the purpose of the BPT is to reduce length of stay.
57. Table 5 is designed to help clarify when the SSEM is applicable and how the adjustment is to be applied in each case.

**Table 5: Application of SSEM**

Best practice tariff	SSEM applicable	SUS applied	Local adjustment required
COPD (new)	Yes	To base price	To conditional

Best practice tariff	SSEM applicable	SUS applied	Local adjustment required
			top-up
Non-ST segment elevation myocardial infarction	No – procedure driven	n/a	n/a
Acute stroke care	No – policy exempt	n/a	n/a
Diabetic ketoacidosis and hypoglycaemia	Yes	To base price	To conditional top-up
Fragility hip fracture	No – policy exempt	n/a	n/a
Heart failure	Yes	To base price	To conditional top-up
Same-day emergency care	No – policy exempt	n/a	n/a
Primary hip and knee replacement outcomes	No – procedure driven	n/a	n/a

58. Providers and commissioners should take this into account when agreeing local data flows and reconciliation processes. Where applicable any local adjustment should be adjusted at the same rate as the core spell (as defined in Annex A).
59. Any adjustments to the tariff, such as specialised service top-ups,<sup>22</sup> are applied to the reduced tariff. Annex A lists the HRGs to which the reduced short stay emergency tariff is applicable.

#### *Long stay payment*

60. A long stay payment on a daily rate basis applies to all HRGs where the length of stay of the spell exceeds a specified trim point<sup>23</sup> specific to the HRG and point of delivery.
61. The trim point is defined in the same way as for reference costs, but is spell based and there are separate elective and non-elective trim points. The trim point for each HRG is shown alongside national prices in Annex A.
62. For 2017 to 2019, there is a trim point floor of five days.<sup>24</sup> There are two long stay payment rates per chapter – one for child-specific HRGs and one for all other HRGs.

<sup>22</sup> Specialised top-ups are paid to reimburse providers for the higher costs of treating patients who require specialised care. Further information is provided in Section 5.

<sup>23</sup> 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.

<sup>24</sup> 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.

63. 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.
64. Long stay payments may only be adjusted when [SUS+](#)<sup>25</sup> applies an adjustment for delayed discharge when the Discharge Ready Date field is submitted in the Commissioning Data Set, by removing the number of days between the ready date and actual discharge date from any long stay payment. Where the Discharge Ready Date field is submitted, providers will wish to satisfy themselves that local authorities are being appropriately charged.

### **3.2.2. Chemotherapy and radiotherapy**

#### *Chemotherapy*

65. HRG subchapter SB covers both the procurement and the delivery of chemotherapy regimens for patients of all ages. The HRGs in this subchapter are unbundled and include activity undertaken in inpatient, day-case and non-admitted care settings.
66. Chemotherapy payment is split into three parts:
- a. a core HRG (covering the primary diagnosis or procedure) – this has a national price
  - b. unbundled HRGs for chemotherapy drug procurement – these have local currencies and prices
  - c. unbundled HRGs for chemotherapy delivery – these have national prices.
67. The regimen list has changed for 2017 to 2019.<sup>26</sup>

#### *Radiotherapy*

68. HRG subchapter SC covers both the preparation and the delivery of radiotherapy for patients of all ages. The HRGs in this subchapter are for the most part unbundled and include activity undertaken in inpatient, day-case and non-admitted care settings.
69. HRG4+ groups for radiotherapy include:
- a. radiotherapy planning for pre-treatment (planning) processes

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<sup>25</sup> <http://content.digital.nhs.uk/sus/replacement>

<sup>26</sup> <http://systems.digital.nhs.uk/data/clinicalcoding/codingstandards/opcs4/chemoregimens>



- b. radiotherapy treatment (delivery per fraction) for treatment delivered, with a separate HRG allocated for each fraction delivered.
- 70. The radiotherapy planning HRGs are intended to cover all attendances needed to complete the planning process. It is not intended to record individual attendances for parts of this process separately.
- 71. The planning HRGs do not include the consultation at which the patient consents to radiotherapy, nor any medical review required by any change in status of the patient.
- 72. The HRGs for radiotherapy treatment cover the following elements of care:
  - a. external beam radiotherapy preparation: this has a national price
  - b. external beam radiotherapy delivery: this has a national price
  - c. brachytherapy and molecular radiotherapy administration: this has local currencies and prices.
- 73. Further information on the structure of the chemotherapy and radiotherapy HRGs and payment arrangements can be found in [Annexes D and F](#).<sup>27</sup>

### **3.2.3. Nuclear medicine**

- 74. To create more appropriate, procedure-specific HRGs to better differentiate the resource use of high cost, complex scans, as well as nuclear medicine procedures, Subchapter RA Diagnostic Imaging Procedures has been deleted and replaced with the following:
  - a. Subchapter RD Diagnostic Imaging Procedures
  - b. Subchapter RN Nuclear Medicine Procedures.
- 75. We note that the scope of activity under HRG4 currencies and HRG4+ currencies does not map exactly.

### **3.2.4. Post-discharge rehabilitation**

- 76. Post-discharge national currencies cover the entire pathway of treatment post discharge. They are designed to help reduce avoidable emergency readmissions and provide a service agreed by clinical experts to facilitate better post-discharge rehabilitation and reablement for patients.<sup>28</sup>
- 77. Post-discharge currencies cover four specific rehabilitation pathways:

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<sup>27</sup> <https://improvement.nhs.uk/resources/national-tariff-1719-consultation>

<sup>28</sup> More information on commissioning rehabilitation services can be found at: [www.england.nhs.uk/wp-content/uploads/2016/04/rehabilitation-comms-guid-16-17.pdf](http://www.england.nhs.uk/wp-content/uploads/2016/04/rehabilitation-comms-guid-16-17.pdf)

a. cardiac rehabilitation

- i. The post-discharge price will only apply to the subset of patients identified as potentially benefitting from cardiac rehabilitation, where the evidence for the effect of cardiac rehabilitation is strongest; that is, those patients discharged having had an acute spell of care for:
  - acute myocardial infarction
  - percutaneous coronary intervention or heart failure
  - coronary artery bypass grafting

b. pulmonary rehabilitation<sup>29</sup>

- i. The post-discharge price will apply to patients discharged having had an acute episode of care for COPD. The national price can be paid only for patients discharged from acute care with an HRG for the spell of care of DZ65A to DZ65K, who subsequently complete a course of pulmonary rehabilitation

c. hip replacement rehabilitation

- i. The national price can only be paid for patients discharged from acute care with an episode of care with a spell dominant procedure of W371, W381, W391, W931, W941 or W951

d. knee replacement rehabilitation.

- i. The national price can be paid only for patients discharged from acute care with an episode of care with a spell dominant procedure coding of W401, W411, W421 or O181.

78. We are continuing with national prices for these four post-discharge currencies for the care of patients where a single provider provides both acute and community services. These prices are listed in Annex A. 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 care pathways.

79. 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.

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<sup>29</sup> Based on the care pathway outlined in the Department of Health's '[Chronic Obstructive Pulmonary Disease \(COPD\) Commissioning Pack](#)'.

80. The post-discharge national prices must be paid on completion of a full rehabilitation pathway.
81. 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.
82. Further information to support the implementation of all four post-discharge currencies, their scope and their specific rules can be found in Annex F guidance on best practice tariffs.

### **3.2.5. Outpatient care**

83. National prices for consultant-led outpatient attendances are based on clinic type categorised according to treatment function code (TFC).<sup>30</sup> There are separate prices for first and follow-up attendances, for each TFC, as well as for single professional and multi-professional clinics.<sup>31</sup>
84. To incentivise a change in the delivery of outpatient follow-up activity, to encourage a move to more efficient models and to free up consultant capacity, we over-reimburse first attendances and under-reimburse corresponding follow-up attendances. This transfer in cost is set at a TFC level and ranges from 10% to 30%. There is a full list in Annex A.
85. The outpatient attendance national price remains applicable only to pre-booked, consultant-led attendances and in accordance with the service conditions in the NHS Standard Contract.<sup>32</sup>
86. When an attendance with a consultant from a different main specialty occurs during a patient's admission and replaces an attendance that would have taken place, it should attract a national price provided it is pre-booked and consultant-led.
87. When a patient has multiple distinct pre-booked outpatient attendances on the same day (eg one 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 local pathway price has been agreed with commissioners.

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<sup>30</sup> TFCs are defined in the NHS Data Model and Dictionary as codes for 'a division of clinical work based on main specialty, but incorporating approved sub-specialties and treatment interests used by lead care professionals including consultants'.

<sup>31</sup> Multi-professional attendances are defined as multiple care professionals (including consultants) seeing a patient together, in the same attendance, at the same time. For more detail see Annex D.

<sup>32</sup> [www.england.nhs.uk/nhs-standard-contract/](http://www.england.nhs.uk/nhs-standard-contract/)

88. Outpatient attendances do not have to take place on 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+ 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.
89. If, following an outpatient attendance, a patient attends an allied health professional (eg a physiotherapist), the costs of the latter attendance are not included in the national price for the original attendance and these attendances will be subject to local price-setting (in accordance with the rules on local pricing).
90. Commissioners and providers should use the NHS Data Model and Dictionary to decide the category of outpatient attendance and day-case activity.<sup>33</sup> 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 included in contracts.
91. For some procedures undertaken in an outpatient setting, there are national prices based on HRGs. If more than one of these procedures is undertaken in a single outpatient attendance, only one price is applicable. The grouper software will determine the appropriate HRG, and the provider will receive payment at the relevant price.
92. Where a procedure-driven HRG is generated, SUS+ determines whether the HRG has a mandatory national price and, if so, applies it. Outpatient procedures for which there is no mandatory HRG price will be paid according to the relevant outpatient attendance national price.
93. For TFCs with no national price, the price should be set through local price setting (in accordance with the rules on local pricing). The national price for any unbundled diagnostic imaging associated with the attendances must be used in all cases. National prices for diagnostic imaging in outpatients are mandatory, regardless of whether or not the core outpatient attendance activity has a national price.
94. As set out in *NHS operational planning and contracting guidance 2017-19*, and linked to the advice and guidance CQUIN, local systems are being encouraged to introduce advice and guidance services as part of plans to manage demand in secondary care acute services. National guidance is being produced by NHS

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<sup>33</sup> 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 healthcare activities in the NHS in England.

England but in the meantime, local health systems should work together to agree a local solution for such services, supported by local data flows.

#### *Non face-to-face activity*

95. To further incentivise the use of new delivery models for follow-up appointments, increased use of non face-to-face appointments or wider adoption of technology, we want to encourage providers and commissioners to agree local prices, at a TFC level, for non face-to-face activity. Reference costs are available as a reference point for local price setting. We would expect any increase in local prices to deliver a reduction in consultant-led face-to-face attendances. To support this, we are no longer publishing a non-mandatory non face-to-face outpatient attendance price as we feel the non-mandatory price published in previous years did not provide an appropriate incentive to move to alternative care models.

#### *Outpatient pathways*

96. The approach to the setting of outpatient follow-up prices does not preclude commissioners and providers agreeing local variations (in accordance with the rules for local variations) that reflect local pathways and/or National Institute for Health and Care Excellence (NICE) guidance, either within the acute setting or across acute and community. Examples of these could include specific pathways of care in dermatology or ophthalmology or cover pathways with more complex patients that do not have a discrete TFC for identification and reimbursement. For more details on local variation (see Section 6).

### **3.2.6. Direct access**

97. There are national prices for activity accessed directly from primary care, which are listed in Annex A. One example is where a GP sends a patient for a scan and results are sent to the GP for follow up rather than such a service being requested as part of an outpatient referral.
98. A field was added to the outpatient Commissioning Data Set version 6.2 which can be used to identify services that have been accessed directly.<sup>34</sup>
99. Where direct access activity is processed through the grouper, both a core HRG and an unbundled HRG will be created. When the activity is direct access, the core HRG should not attract any payment but the direct access service should attract a payment.

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<sup>34</sup> SUS R16 release (April 2016) has a requirement to add new functionality to implement the CDS6.2 new data item 'Direct access indicator'.

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

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

### **3.2.7. Urgent and emergency care**

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

103. Where a patient is admitted following an A&E attendance, both the relevant A&E and non-elective prices are payable. Please note that the tariff for patients who are 'dead on arrival' (DOA) should be that applying to VB99Z.

104. 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 VA1Z only.

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

### **3.2.8. Best practice tariffs**

106. A BPT is a national price that is designed to incentivise quality and cost-effective care. The first BPTs were introduced in 2010/11 following Lord Darzi's 2008 review.<sup>35</sup>

107. The aim is to reduce unexplained variation in clinical quality and spread best practice. BPTs may introduce an alternative currency to an HRG, including a description of activities that more closely corresponds to the delivery of outcomes for a patient. An incentive to move from usual care to best practice is created by creating a price differential between agreed best practice and usual care. More detail on the method for setting BPT prices can be found in Section 4.

108. Where a BPT introduces an alternative currency, that currency should be used in the cases described here, and set out in Annexes A, D and F.

109. 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:

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<sup>35</sup> *High quality care for all*, presented to Parliament in June 2008.

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

110. The service areas covered by BPTs are all:

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

111. A breakdown of the BPTs and the eligibility criteria are provided in Table 5.

112. For 2017/19, the NTPS includes two new mandatory BPTs for:

- a. chronic obstructive pulmonary disease (COPD) care
- b. improving the time from a patient being admitted to receiving coronary angioplasty for patients with NSTEMI.

113. There are also changes to five BPTs:

- a. day-case procedures
- b. fragility hip fracture
- c. primary hip and knee replacements
- d. same-day emergency care
- e. acute stroke care.

114. The 2017/19 NTPS no longer includes the BPT for interventional radiology. This is because the adoption of HRG4+ makes it unnecessary.

115. Some BPTs relate to specific HRGs (HRG-level) while others are more detailed and relate to a subset of activity in an HRG (sub-HRG). The BPTs that are set at a more detailed level are identified by 'BPT flags'. For sub-HRG level BPTs there will be other activity covered by the HRG that does not relate to the BPT activity, and so a 'conventional' price is also published for these HRGs to reimburse the costs of the activity unrelated to the BPT. For more information relating to the BPT flags see Annex A.

116. Top-up payments for specialised services and long stay payments apply to all of the relevant BPTs. The short stay emergency adjustment (SSEM) is not

universally applicable to BPTs. Details of how the adjustment is to be applied in each case is set out above in the section relating to SSEM (Section 3.2.1).

117. Table 6 sets out a summary of the best practice tariffs, and further detailed guidance is available in Annex F.

**Table 6: Summary of best practice tariffs**

BPT	Eligibility criteria
Acute stroke care (amended 2017/19)	<p>The BPT is made up of three conditional payment levels:</p> <ul style="list-style-type: none"> <li>• Patients admitted directly to an acute stroke unit either by the ambulance service, from A&amp;E or via brain imaging. Patients must not be admitted directly to a medical assessment unit. Patients must be seen by a consultant with stroke specialist skills in 14 hours of admission. Patients must then also spend most of their stay in the acute stroke unit.</li> <li>• Initial brain imaging is delivered within 12 hours of admission.</li> <li>• Patients are assessed for thrombolysis, receiving alteplase if clinically indicated in accordance with the NICE technology appraisal TA264 'Alteplase for treating acute, ischaemic stroke'.</li> </ul>
Adult renal dialysis (haemodialysis)	<p>The BPT requires vascular access via a functioning arteriovenous fistula. Therefore, renal units will need to collaborate with surgical services to establish processes that facilitate timely referral for formation of vascular access</p>
Adult renal dialysis (Home haemodialysis)	<p>The BPT price for home haemodialysis will reflect a week of dialysis, irrespective of the number of dialysis sessions prescribed.</p> <ul style="list-style-type: none"> <li>• The BPT price covers the direct costs of dialysis as well as the associated set-up, removal and utility costs incurred by the provider (eg preparation of patients' homes, equipment and training).</li> </ul>
Chronic obstructive pulmonary disease (COPD) (new 2017/19)	<p>Best practice would be considered achieved when:</p> <ul style="list-style-type: none"> <li>• 60% of patients with a primary diagnosis of COPD, admitted for an exacerbation of COPD, receive specialist input in to their care within 24 hours of admission, and</li> <li>• where they receive a discharge bundle before discharge as measured by the national COPD audit.</li> </ul>
Day-case procedures (amended 2017/19)	<ul style="list-style-type: none"> <li>• The BPT is made up of a pair of prices for each of the procedures listed in Annex A; one applied to day-case admissions (higher) and one applied to ordinary elective admissions (lower). Annex A details the prices, whether</li> </ul>



BPT	Eligibility criteria
	<p>they apply at HRG or sub-HRG (with BPT flag) and the relevant OPCS codes.</p>
<p>Diabetic ketoacidosis and hypoglycaemia</p>	<p>The BPT applies only to adults admitted as an emergency with diabetic ketoacidosis or hypoglycaemia.</p> <p>The BPT is made up of two components: a base price and a conditional payment. The base price is payable for all activity irrespective of whether best practice was met. The conditional payment is payable if the patient receives all the following care:</p> <ul style="list-style-type: none"> <li>referred to the diabetes specialist team (DST) on admission, and seen within 24 hours by a member of the DST</li> <li>has an education review by a member of the DST before discharge</li> <li>is seen by a diabetologist or diabetic specialist nurse before discharge</li> <li>discharged with a written care plan (which allows the person with diabetes to be actively involved in deciding, agreeing and taking responsibility for how their diabetes is managed) that is copied to their GP</li> <li>offered access to structured education, with the first appointment scheduled to take place within three months of discharge.</li> </ul>
<p>Early inflammatory arthritis</p>	<p>There are three separate BPT payments applicable where care meets the standards set out below.</p> <ul style="list-style-type: none"> <li>Diagnosis and discharge</li> </ul> <p>For those patients with suspected early inflammatory arthritis who are:</p> <ul style="list-style-type: none"> <li>seen within three weeks of referral</li> <li>diagnosed as not having early inflammatory arthritis and discharged within six weeks of referral.</li> </ul> <p>The BPT includes the costs of plain radiology, ultrasounds, all blood tests, and clinical consultations with doctors/nurses.</p> <ul style="list-style-type: none"> <li>Disease-modifying antirheumatic drugs (DMARD) therapy</li> </ul> <p>For those patients with suspected early inflammatory arthritis who:</p>

BPT	Eligibility criteria
	<ul style="list-style-type: none"> <li>• are seen within three weeks of referral</li> <li>• start DMARD treatment in six weeks of referral</li> <li>• receive regular follow-up and monitoring over first year of treatment with evidence of appropriate titration of therapy.</li> </ul> <p>The BPT price includes the annual costs of all blood tests, non-biological prescriptions, clinical consultations with doctors/nurses, and annual review. The price excludes physiotherapy, psychology, podiatry, occupational therapy, telephone emergency advice line, inpatient admissions, biologics and associated drug costs.</p> <ul style="list-style-type: none"> <li>• Biological therapy</li> </ul> <p>For patients with suspected early inflammatory arthritis who:</p> <ul style="list-style-type: none"> <li>• are seen in three weeks of referral</li> <li>• have DMARD treatment initiated in six weeks of referral</li> <li>• receive regular follow-up and monitoring over first year of treatment</li> <li>• meet NICE eligibility criteria for biological therapy and biologics are prescribed and initiated in year 1.</li> </ul> <p>The BPT price includes the annual costs of all blood tests, non-biologic prescriptions, clinical consultations with doctors/nurses, and annual review. The price excludes physiotherapy, psychology, podiatry, occupational therapy, telephone emergency advice line, inpatient admissions, biologics, drug infusion and associated costs.</p>
Endoscopy procedures	<p>The BPT applies to adults only for elective endoscopic procedures in all NHS providers (including community organisations) and independent sector providers.</p> <ul style="list-style-type: none"> <li>• providers achieving BPT Level 1 Joint Advisory Group (JAG) accreditation will be reimbursed at the full BPT price</li> <li>• providers achieving BPT Level 2 will receive a price 2.5% below the BPT price</li> <li>• providers at BPT Level 3 will receive a price 5% below the</li> </ul>

BPT	Eligibility criteria
	<p>BPT price.</p> <ul style="list-style-type: none"> <li>each month JAG will publish a list indicating each endoscopy unit's BPT level.<sup>36</sup></li> </ul>
Fragility hip fracture (amended 2017/19)	<p>The BPT is made up of two components: a base price and a conditional payment. The base price is payable to all activity irrespective of whether the characteristics of best practice are met. The conditional payment is payable only if all the following characteristics are achieved:</p> <ul style="list-style-type: none"> <li>time to surgery within 36 hours from arrival in an emergency department, or time of diagnosis if an admitted patient, to the start of anaesthesia</li> <li>assessed by a geriatrician in the perioperative period (within 72 hours of admission)</li> <li>fracture prevention assessments (falls and bone health)</li> <li>an abbreviated mental test performed before surgery and the score recorded in National Hip Fracture Database (NHFD)</li> <li>a nutritional assessment during the admission</li> <li>a delirium assessment using the 4AT screening tool during the admission</li> <li>assessed by a physiotherapist on the day of or day following surgery.</li> </ul> <p>Commissioners determine compliance with best practice using reports compiled from data submitted by providers to the NHFD.</p>
Heart failure	<p>The BPT is made up of two components: a base price and a conditional payment. The base price is payable to all activity irrespective of whether the characteristics of best practice are met. The conditional payment is payable only if all of the following characteristics are achieved:</p> <ul style="list-style-type: none"> <li>data submission to the National Heart Failure Audit (NHFA) with a target rate of 70%: this means that at least 70% of all eligible records need to be submitted to the NHFA.</li> <li>specialist input with a target rate of 60%: this means that at least 60% of all patients recorded in the heart failure audit have received specialist input as defined by the NHFA.</li> </ul>

<sup>36</sup> [www.thejag.org.uk/Commissioning/BestPracticeTariffStatus.aspx](http://www.thejag.org.uk/Commissioning/BestPracticeTariffStatus.aspx)

BPT	Eligibility criteria
Major trauma care	<p>The BPT is made up of two levels of payment differentiated by the patients' injury severity score (ISS) and conditional on achieving the criteria below.</p> <p>A Level 1 BPT is payable for all patients with an ISS of more than eight providing that:</p> <ul style="list-style-type: none"> <li>• the patient is treated in a major trauma centre</li> <li>• Trauma Audit and Research Network (TARN) data are completed and submitted within 25 days of discharge</li> <li>• a rehabilitation prescription is completed for each patient and recorded on TARN</li> <li>• any coroners' cases flagged in TARN as being subject to delay to allow later payment</li> <li>• tranexamic acid is administered within three hours of injury for patients receiving blood products</li> <li>• if the patient is transferred as a non-emergency they must be admitted to the major trauma centre within two calendar days of referral from the trauma unit.</li> </ul> <p>A Level 2 BPT is payable for all patients with an ISS of 16 or more providing Level 1 criteria are met and that:</p> <ul style="list-style-type: none"> <li>• if the patient is admitted directly to the major trauma centre or transferred as an emergency, they must be received by a trauma team led by a consultant in the major trauma centre. The consultant can be from any specialty, but must be present within five minutes</li> <li>• if the patient is transferred as a non-emergency they must be admitted to the major trauma centre within two calendar days of referral from the trauma unit</li> <li>• patients admitted directly to a major trauma centre with a head injury (AIS 1+) and a Glasgow Coma Scale (GCS) score of less than 13 (or intubated pre-hospital), and who do not require emergency surgery or interventional radiology within one hour of admission, receive a head CT scan within 60 minutes of arrival.</li> </ul>
NSTEMI (new 2017/19)	<p>The BPT is made up of two components: a base price and a conditional payment. The base price is payable to all activity irrespective of whether the characteristics of best practice are met.</p> <p>Best practice will be considered achieved where 60% of NSTEMI patients receive coronary angiography (with follow-on percutaneous coronary intervention if indicated) within 72</p>

BPT	Eligibility criteria
	<p>hours of first admission to hospital.</p> <p>Success against the best practice criteria is measured at provider level and for the provider who undertakes the procedure.</p>
Outpatient procedures	<p>The BPTs for all three outpatient procedures apply at the HRG level. SUS+ will automate payment by applying the relevant prices to the HRG. Annex A details the prices, relevant HRGs and the relevant OPCS codes.</p> <p>To qualify for the outpatient BPT, the procedure must occur and be coded to an outpatient setting as defined by the NHS Data Model and Dictionary.</p>
Paediatric diabetes	<p>Where commissioners are satisfied the standards have been achieved, the BPT must be paid for all the young people attending the clinic. It is expected that compliance with all criteria will need to be demonstrated for at least 90% of patients attending the clinic.</p> <p>The best practice service specification is:</p> <ul style="list-style-type: none"> <li>• On diagnosis, a young person's diabetes is discussed with a senior member of the paediatric diabetes team within 24 hours of presentation. A senior member is defined as a doctor or paediatric specialist nurse with 'appropriate training' in paediatric diabetes. Information on what constitutes 'appropriately trained' is available from the British Society for Paediatric Endocrinology and Diabetes or the Royal College of Nursing.</li> <li>• All new patients must be seen by a member of the specialist paediatric diabetes team on the next working day.</li> <li>• Each provider unit can provide evidence that each patient has received a structured education programme, tailored to the child or young person's and their family's needs, both at initial diagnosis and at ongoing updates throughout the child or young person's attendance at the paediatric diabetes clinic.</li> <li>• Each patient is offered a minimum of four clinic appointments per year with a multidisciplinary team (MDT), defined as including a paediatric diabetes specialist nurse, dietitian and doctor. At every visit, the child must be seen by the doctor, who must be a consultant or associate specialist/ specialty doctor with training in paediatric diabetes or a specialist registrar training in paediatric diabetes, under the supervision of an appropriately trained consultant (see above). The dietitian must be a paediatric dietitian with training in diabetes (or equivalent appropriate experience).</li> <li>• Each patient is offered additional contact by the diabetes</li> </ul>

BPT	Eligibility criteria
	<p>specialist team for check-ups, telephone contacts, school visits, troubleshooting, advice, support etc. Eight contacts per year are recommended as a minimum.</p> <ul style="list-style-type: none"> <li>• Each patient is offered at least one extra appointment per year with a paediatric dietitian with training in diabetes (or equivalent appropriate experience).</li> <li>• Each patient is offered a minimum of four haemoglobin HbA1C measurements per year. All results must be available and recorded at each MDT clinic appointment.</li> <li>• All eligible patients must be offered annual screening as recommended by current NICE guidance. Retinopathy screening must be performed by regional screening services in line with the national retinopathy screening programme, which is not covered by the paediatric diabetes BPT and is funded separately. Where retinopathy is identified, timely and appropriate referral to ophthalmology must be provided by the regional screening programme.</li> <li>• Each patient must have an annual assessment by their MDT of whether they need input to their care by a clinical psychologist, and access to psychological support, which should be integral to the team, as appropriate.</li> <li>• Each provider must take part in the annual Paediatric National Diabetes Audit.</li> <li>• Each provider must take part in the local paediatric diabetes network. A contribution to the funding of the network administrator will be required. A minimum of 60% attendance at regional network meetings needs to be demonstrated. They should also take part in peer review.</li> <li>• Each provider unit must provide patients and their families with 24-hour access to advice and support. This should also include 24-hour expert advice to fellow health professionals on the management of patients with diabetes admitted acutely, with a clear escalation policy on when further advice on managing diabetes emergencies should be sought. A provider of expert advice must be fully trained and experienced in managing paediatric diabetes emergencies.</li> <li>• Each provider unit must have a clear policy for transition to adult services.</li> <li>• Each unit will have an operational policy, which must include:</li> </ul>

BPT	Eligibility criteria
	<ul style="list-style-type: none"> <li>○ a structured 'high HbA1C' policy</li> <li>○ a clearly defined 'did not attend' (DNA)/was not brought policy taking into account local safeguarding children board policies and evidence of patient feedback on the service.</li> <li>• If the young person is not registered with a provider, the admitting provider must invoice the relevant commissioner. If a patient is referred elsewhere for a second opinion, shared care or full transfer of care, subsequent division of funding will need to be agreed between the referring and receiving centres.</li> </ul>
Paediatric epilepsy	<p>The BPT is a payment for each attendance for follow-up appointments and covers outpatient care after first acute or outpatient assessment for patients with a diagnosis of probable epilepsy until they transfer to adult services. Activity meeting the best practice criteria must be coded against the TFC223 Paediatric Epilepsy.</p> <p>The BPT is payable to providers of a service that meets the following criteria:</p> <ul style="list-style-type: none"> <li>• Paediatric consultants with expertise in epilepsies lead the service with epilepsy specialist nurses (ESNs) performing an integral role.</li> <li>• Patients have a comprehensive care plan that is agreed between the patient, family and/or carers and both the paediatric consultant with expertise in epilepsies and the ESN. This must cover lifestyle issues as well as medical issues.</li> <li>• The follow-up appointments provide enough time with both the paediatric consultant (or associate specialist) with expertise in epilepsies and the ESN to manage the patient against the agreed care plan. As a guide, it is expected that the patient spends at least 20 minutes with each professional (either at the same time or in successive slots). All children with epilepsy must be able to be reviewed when clinically required. Outpatient booking systems must be able to guarantee these follow-up appointments.</li> <li>• The service has evidence of shared care and referral pathways to tertiary paediatric neurology services, transition and referral pathways to adult services, and continuing full participation in the Epilepsy 12 national audit.</li> <li>• The BPT is a payment for each attendance for follow-up appointments and covers outpatient care after first acute or outpatient assessment, for patients with a diagnosis of</li> </ul>



BPT	Eligibility criteria
	probable epilepsy until they transfer to adult services.
Parkinson's disease	<p>The BPT applies to adults with a probable diagnosis of Parkinson's disease where care during the first year is delivered in line with the criteria detailed below:</p> <ul style="list-style-type: none"> <li>• Referrals from primary care with suspected Parkinson's disease must be seen by a movement disorder specialist (neurology/elderly care) within six weeks. These timescales are applicable to all patients for the purposes of the BPT, but the expectation is that new referrals in later stages of disease with more complex problems will continue to be seen within two weeks.</li> <li>• Each patient must receive regular follow-up and diagnostic review with a specialist nurse at least every six months with a process in place to identify the appropriate period of follow-up. Each patient must have a nominated person identified to continue with follow-up and diagnostic review.</li> <li>• All patients must be referred to a Parkinson's disease nurse specialist (PDNS) (local names may include neurology nurse specialist or movement disorder specialist) who will be responsible for co-ordinating care.</li> <li>• Evidence to demonstrate that the provider is using recognised tools: for example, patient feedback, non-motor symptom (NMS) screening tool and cognitive assessment tool.</li> <li>• Patients must be offered therapy assessment within one year (including physiotherapist, speech and language therapist and occupational therapist). The costs of the therapy assessment are not included in the BPT. However, payment is dependent on therapy assessment being offered (irrespective of whether patient takes this up).</li> </ul>
Pleural effusions	<p>The aim of this BPT is to incentivise a shift in activity away from non-elective admissions to pleural effusions being performed on a planned elective basis under ultrasound control.</p> <p>This is achieved by setting the price for day-case admissions relatively higher than the non-elective price, therefore creating a financial incentive for managing patients on an elective basis.</p> <p>In setting the BPT, we have assumed that 50% of current emergency admissions to DZ16N are suitable to be managed on a day-case basis (YD04Z or YD05Z).</p>



BPT	Eligibility criteria
<p>Primary hip and knee replacement outcomes (amended 2017/19)</p>	<p>The criteria for payment of the BPT are:</p> <ul style="list-style-type: none"> <li>• the provider not having an average health gain significantly below the national average</li> <li>• the provider adhering to the following data submission standards: <ul style="list-style-type: none"> <li>○ a minimum patient-reported outcome measures (PROMs) participation rate of 50%</li> <li>○ a minimum National Joint Registry (NJR) compliance rate of 85%</li> <li>○ an NJR unknown consent rate below 15%.</li> </ul> </li> </ul> <p>Providers will not receive the BPT if they are either:</p> <ul style="list-style-type: none"> <li>• below the lower 99.8% control limit based on the most recently published data or</li> <li>• below the lower 95% control limit based on the most recently published previous two years data.</li> </ul> <p>Commissioners will need to monitor PROMs and NJR publications to determine whether providers are complying with the payment criteria. Where they are not, commissioners should make manual adjustments to the base (non-best practice) price until an improvement is shown in the published data and the requirements of the BPT are met (unless subject to the national variation).</p>
<p>Same-day emergency care (amended 2017/19)</p>	<p>The BPT for each clinical scenario listed in Annex A is made up of a pair of prices: one applied to emergency admissions with a zero day length of stay (higher), the other to emergency admissions with a stay of one or more days (lower).</p> <p>It is not expected that the rate of emergency admissions will increase as a result of introducing the BPT for the clinical scenarios. It would be expected that either the rate remains constant with the proportion of zero stays increasing, or the rate reduces as providers implement more same-day emergency care pathways appropriate to a non-admitted setting.</p>

### 3.2.9. Looked after children health assessments

118. Looked after children<sup>37</sup> are one of the most vulnerable groups in society.
119. One-third of all looked after children are placed with carers or in settings outside the originating local authority. These are referred to as 'out-of-area' placements.
120. 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.
121. 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.
122. To address this variability in the arrangements for children placed out of area and to enable more timely assessments, a currency was devised and mandated. A checklist for implementing the currency is included in Annex D.
123. National prices apply for children placed out of area, these can be found under 'Other National Prices' in Annex A. When a looked after child is placed 'out of area', the responsible commissioner must commission providers in the receiving area to undertake the health assessments and pay them using the national price.
124. There is a non-mandatory currency but no mandatory currencies or national prices for in-area health assessments for looked after children. In setting prices, commissioners and providers must adhere to the relevant rules and principles set out in the locally determined prices section of the national tariff. We have made non-mandatory prices available for children placed in area to support the development of local prices.

### 3.2.10. Pathway payments

125. Pathway payments are single payments that cover a bundle of services<sup>38</sup> which may be provided by several providers for an entire episode or whole pathway of

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<sup>37</sup> 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".

<sup>38</sup> 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.

care for a patient. They 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 care settings (eg primary, secondary, community services and social care), has the potential to improve patient outcomes by reducing complications and readmissions.

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

- a. maternity healthcare services
- b. healthcare for patients with cystic fibrosis.

#### *Maternity pathway payment*

127. The maternity pathway payment system splits maternity care into three stages: antenatal, delivery and postnatal. For each stage, a woman chooses her pathway provider, identified as the 'lead provider'. The commissioner makes a single payment to the lead provider of each stage to cover the cost of care,<sup>39</sup> the level of which depends on clinical factors that affect the extent and intensity of care a woman is expected to need.

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

129. For 2017/19, we have updated the casemix assumptions for the antenatal pathway to increase the activity allocated to the intermediate and intensive levels. This means that the allocation at standard level would be reduced and relative weightings between the standard, intermediate and intensive prices will change. This policy will help to ensure that providers are more appropriately reimbursed for the care they provide. More detail on this can be found in Section 4.3.4.

130. Table 7 sets out what is included and excluded from all three stages of the maternity payment system. Besides the exceptions identified, there should be no further payments for individual elements of activity along the pathway.

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<sup>39</sup> Antenatal care for uncomplicated pregnancies [www.nice.org.uk/guidance/cg62/chapter/guidance](http://www.nice.org.uk/guidance/cg62/chapter/guidance)

**Table 7: The maternity pathway payment system**

Area	Included	Excluded
Admitted patient care	All activity against NZ* HRGs (regardless of TFC) This includes all foetal medicine, including that provided by tertiary providers <sup>40</sup>	All activity against non-NZ* HRGs (regardless of TFC)
Outpatient care	All activity against NZ* HRGs (regardless of TFC) All attendance activity against TFC 501 (obstetrics) and 560 (midwife episode) <ul style="list-style-type: none"> <li>- includes all foetal medicine, including that provided by tertiary providers</li> <li>- includes any activity in emergency gynaecology or early pregnancy units that codes to 'NZ' HRGs, even if before the antenatal assessment visit</li> </ul>	All activity against non-NZ* HRGs (except with a TFC of 501 or 560) An attendance TFC other than 501 (obstetrics) or 560 (midwife episode) Emergency gynaecology and early pregnancy activity will normally code to TFC502 or non NZ* HRGs and will therefore be excluded
Antenatal education	Antenatal education activity	
Critical care		All critical care activity
Community/primary care	All maternity community-based antenatal and postnatal care	All primary care activity applicable to payment under the GP contract. A woman may choose some of her maternity pathway to be delivered by her GP or for the practice to be the lead pathway provider, but any care delivered by the GP will be paid under the GP contract
Scans, screening and tests	All maternity ultrasound scans, and all relevant maternal and newborn screening that is part of National Screening Programmes <sup>41</sup>	The analysis elements of the screening process undertaken by specialist diagnostic laboratories under a separate commissioner contract
Immunisation	All specified immunisation of	

<sup>40</sup> It is expected that from 2014/15 foetal medicine has been coded differently, which should facilitate separate commissioning for this service in the future.

<sup>41</sup> Further information can be found in the NHS England publication 'Who pays for antenatal and newborn screening?' at [www.england.nhs.uk/expo/wp-content/uploads/sites/18/2015/06/who-pays-mpp-upd-06-2015.pdf](http://www.england.nhs.uk/expo/wp-content/uploads/sites/18/2015/06/who-pays-mpp-upd-06-2015.pdf)

Area	Included	Excluded
	the newborn that should occur before handover to primary care	
Birth	The birth, irrespective of type and setting	
Post-birth care	Well/healthy babies, both during the delivery module and pathway checks/screening during the postnatal module	Pathways for unwell/unhealthy babies. Babies requiring admitted patient care treatment will have their own admission record
Pre-pregnancy care		All pre-pregnancy/pre-conception care and reproductive services
Non-maternity care	Advice on risks in the context of pregnancy and referral to other relevant professionals where necessary for resolution if possible	All activity that is the named responsibility of other professionals or providers who receive payment to deliver that care for the population (eg drug and alcohol services, mental health services, stopping smoking services, weight management services, etc)
Specialised services	All foetal medicine, including that provided by tertiary providers	All activity paid for directly by NHS England
Ambulance transfers		All ambulance transfer costs
Accident and emergency		All unscheduled A&E activity
Clinical Negligence Scheme for Trusts (CNST)	All CNST costs are included	
High cost drugs and devices		All specified high cost drugs and devices not covered by national prices

131. Further information on the pathway payment approach can be found in Annexes A and D.

#### *Cystic fibrosis pathway payment*

132. The cystic fibrosis (CF) 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.

133. The pathway payments cover all treatment directly related to cystic fibrosis for a patient during the financial year. This includes:

- admitted patient care and outpatient attendances (whether delivered in a specialist centre or under shared network care arrangements)
- home care support, including home intravenous antibiotics supervised by the CF service, home visits by the multidisciplinary team to monitor a patient's condition, eg management of totally implantable venous access devices (TIVADs), collection of mid-course aminoglycoside blood levels and general support for patient and carers
- intravenous antibiotics provided during inpatient spells
- annual review investigations.

134. 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.

135. Further information is provided in Annex A and supporting guidance.

### **3.3. High cost drugs, devices and listed procedures**

136. Several high cost drugs, devices and listed procedures are not reimbursed through national prices. Instead they are subject to local pricing in accordance with the rules set out in Section 6. These can be found on the high cost lists in Annex A. If they are not on this list, and are part of a nationally priced treatment or service, then the cost of the drug, device or listed procedure is covered by the national price. It should be noted that high cost drugs are excluded either individually or as a group exclusion, as indicated in Annex B.

137. Where a provider and commissioner believe that the national price does not cover the cost of the drug or device, in addition to the other costs of treating the patient, then a local variation can be agreed between provider and commissioner, in accordance with local pricing rules, to facilitate an additional payment.

138. For the 2017/19 NTPS we have updated the list of drugs, devices and procedures using the same criteria used in previous years.<sup>42</sup> Annex A sets out the details.

*New listed procedures: molecular and companion diagnostics and personalised medicine*

139. In 2016/17 NHS England provided a list of list of molecular diagnostic tests for exclusion. This list remains the same for 2017 to 2019. Details of the excluded tests can be found under the heading of listed procedures on the high cost drugs, devices and listed procedures list in Annex A.

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

### **3.4. The innovation and technology tariff**

141. We are introducing a new innovation and technology tariff (ITT) with the aim of setting incentives to encourage the uptake and spread of innovative medical technologies that benefit patients.

142. The development of innovations is encouraged through the NHS Innovation Accelerator (NIA),<sup>43</sup> the NHS test beds, and the Commissioning through Evaluation Programme.

143. Innovations that have been accepted on to the NIA process were subject to an assessment by NHS England of suitability for inclusion in the ITT.

144. This assessment was made against a range of factors such as whether the service that would utilise the innovation is currently in the scope of the national tariff, how widespread the innovation is in the sector and whether the innovation is suitable for pricing in the national tariff. Working with UCL Partners and clinicians from the NIA process, and also subject matter experts, NHS England has identified a range of innovations suitable for inclusion in the ITT.

145. The innovations that are included in the ITT for 2017/19 are listed below.

146. Recognising the concerns of the sector, NHS England is committed to funding CCGs to implement these innovations. For five of the six innovation categories, NHS England will reimburse commissioners for this cost in addition to its commissioner allocations. The sixth category, treatment of lower urinary tract

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<sup>42</sup> Further information about high cost drugs, devices and procedures may be found online via the high cost drugs, devices and chemotherapy portals [www.england.nhs.uk/resources/pay-syst/drugs-and-devices/](http://www.england.nhs.uk/resources/pay-syst/drugs-and-devices/)

<sup>43</sup> [www.england.nhs.uk/ourwork/innovation/nia/](http://www.england.nhs.uk/ourwork/innovation/nia/)

symptoms of benign prostatic hyperplasia as a day case, is already included in national prices.

147. NHS England intends to agree fixed prices with manufacturers for five of the six products covered by the ITT. These prices can be found in the supporting document for the ITT. We expect that these prices will be adopted in local agreements between providers and commissioners so there should be no need for further negotiation of the price. The five innovations to be locally priced are not included within the currencies used to set national prices. This approach is similar to the approach adopted for high cost drugs and devices that are also subject to the local pricing rules

### **3.4.1. Guided mediolateral episiotomy to minimise the risk of obstetric anal sphincter injury**

#### *Innovation detail*

148. Approximately 15% of births in England require an episiotomy. Of these, around 25% experience obstetric anal sphincter injuries (OASIS). The angle of the cut is important and NICE guidance recommends that cuts need to be between 45 and 60 degrees to reduce the incidence of poor patient outcomes, reconstructive surgery and litigation costs. The use of angled scissors in episiotomies therefore should improve patient experience and outcomes and reduce OASIS repair and litigation.

#### *Further information*

149. Further information is available at:

- a. [www.nice.org.uk/advice/miC3/chapter/introduction](http://www.nice.org.uk/advice/miC3/chapter/introduction)
- b. [www.nice.org.uk/guidance/cg190/chapter/1-Recommendations#third-stage-of-labour](http://www.nice.org.uk/guidance/cg190/chapter/1-Recommendations#third-stage-of-labour)

### **3.4.2. Arterial connecting systems to reduce bacterial contamination and the accidental administration of medication**

#### *Innovation detail*

150. Arterial line placement is a common procedure in various critical care settings. Intra-arterial blood pressure (BP) measurement is more accurate than measurement of BP by non-invasive means, especially in the critically ill. Although rare, when wrong route drug administration occurs, it has the potential to cause serious damage to the vessel and surrounding tissue. Arterial cannulation is associated with complications including bacterial contamination, accidental intra-arterial injection and blood spillage.



151. Needle-free connectors prevent blood spillage and through a one-way valve allow aspiration only thus preventing accidental administration of medication to the arterial line.

*Further information*

152. Further information can be found at the [Eastern Academic Health Science Network](#).<sup>44</sup>

### **3.4.3. Prevention of ventilator-associated pneumonia in critically ill patients**

*Innovation detail*

153. Ventilator-associated pneumonia (VAP) is defined as pneumonia that occurs 48 to 72 hours or thereafter following endotracheal intubation, characterised by the presence of a new or progressive infiltrate, signs of systemic infection (fever, altered white blood cell count), changes in sputum characteristics, and detection of a causative agent. Approximately 100,000 patients are admitted for ventilation in critical care units in the UK each year. The risk for patients is highest during early ICU stay when it is estimated to be 3% per day during days 1 to 5 of ventilation, 2% per day during days 5 to 10 of ventilation and 1% per day thereafter (Masterton, 2008).
154. On average 10% to 20% (10,000 to 20,000) patients will be diagnosed with VAP resulting in an attributable mortality rate of about 30% or between 3,000 and 6,000 deaths. Each episode of VAP has an estimated cost to the NHS of between £10,000 and £20,000.
155. Improved airway management in critically ill patients who are having mechanical ventilation can prevent ventilator-associated pneumonia by minimising the risk of pulmonary aspiration and micro-aspiration in patients having ventilation for 24 hours or more. This could see a reduction in the length of time spent on ventilation and length of stay in ICU.
156. There are available pneumonia prevention systems which are designed to stop VAP through the use of a cuffed ventilation tube and an electronic cuff monitoring and inflating device which prevents leakage of bacterial laden oral and stomach contents to the lung – a problem associated with standard tubes.

*Further information*

157. NICE has produced a Medtech Innovation Briefing<sup>45</sup> (MIB) which identified three studies including one randomised control trial and two retrospective cohort studies.

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<sup>44</sup> [www.eahsn.org/our-work/casestudies/non-injectable-arterial-connector/](http://www.eahsn.org/our-work/casestudies/non-injectable-arterial-connector/)

### **3.4.4. Application for the self-management of chronic obstructive pulmonary disease**

#### *Innovation detail*

158. Managing chronic obstructive pulmonary disease (COPD) costs the NHS more than £1 billion each year. However, treatment is complex, with different inhalers needing to be used in different ways. Compliance with treatment is often extremely low, leading to poor outcomes and wasted prescribing. For this reason, improving self-management for patients with COPD is a key priority for the NHS.
159. There is no cure for COPD and good symptom management is essential to stabilise disease and prevent recurrent flare-ups or exacerbations. Exacerbations often require intensive treatment and can be severe enough to require hospital admission.
160. There is evidence from recent studies that disease-specific self-management improves health status and reduces hospital admissions in COPD patients. It is critical to implement health education programmes in the continuum of care aimed at behaviour modification. Studies in COPD have shown that self-management increases knowledge and skills the patients require to treat their own illness.
161. A number of a web-based and iOS applications that help patients manage their condition more effectively are available. These platforms can interface with clinical dashboards to monitor and manage their patients remotely at an individual and population level.
162. These platforms can also be used by local healthcare providers and CCGs to monitor exacerbation burdens in real time and review potential inequalities in healthcare to plan support services effectively.

#### *Further information*

163. NICE has produced [guidance on the management of COPD](#).<sup>46</sup>

### **3.4.5. Frozen faecal microbiota transplantation for recurrent *Clostridium difficile* infection rates**

#### *Innovation detail*

164. *Clostridium difficile* infection (CDI) rates are climbing in frequency and severity, and the spectrum of susceptible patients is expanding beyond the traditional

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<sup>45</sup> [www.nice.org.uk/advice/miD5](http://www.nice.org.uk/advice/miD5)

<sup>46</sup> [www.nice.org.uk/guidance/CG101](http://www.nice.org.uk/guidance/CG101)

scope of hospitalised patients receiving antibiotics. There are over 3,000 new cases of chronic CDI across England per year. Faecal microbiota transplantation (FMT) is becoming increasingly accepted as an effective and safe intervention in patients with recurrent disease, probably due to the restoration of a disrupted microbiome. Cure rates of > 90% are being consistently reported from multiple centres. FMT is the provision of a screened specially prepared stool administered via a nasal tube into the intestine to restore the balance of bacteria in the gut. FMT is a NICE-recommended treatment for chronic CDI.

165. To date nine trusts have performed FMTs on their own site via the frozen service.

#### *Further information*

166. NICE has produced [interventional procedures guidance](#) for this technology as part of the pathway for gastrointestinal conditions.<sup>47</sup>

### **3.4.6. Treatment of lower urinary tract symptoms of benign prostatic hyperplasia as a day case**

#### *Innovation detail*

167. Benign prostatic hyperplasia (BPH) is a common and chronic condition where the enlarged prostate can make it difficult for a man to pass urine, leading to urinary tract infections, urinary retention, and in some cases renal failure. Existing treatment transurethral resection of the prostate (TURP) involves cutting away or removing existing tissue, and requires an average hospital stay of three days and often catheterisation for many days post-surgery.
168. In people with benign prostatic hyperplasia, the prostate becomes enlarged. A prostatic urethral lift system uses adjustable, permanent implants to hold the enlarged prostate away from the urethra so that it isn't blocked. In this way, the device can relieve lower urinary tract symptoms (such as pain or difficulty when urinating).
169. Healthcare teams may want to use a prostatic urethral lift system as an alternative to transurethral resection of the prostate and holmium laser enucleation of the prostate (HoLEP).

#### *Payment/price detail*

170. For the purposes of reimbursement, this cost is included in tariff, reported via SUS+ and charged per spell.

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<sup>47</sup> [www.nice.org.uk/guidance/ipg485](http://www.nice.org.uk/guidance/ipg485)

171. Providers should use combination code M678 (Other specified other therapeutic endoscopic operations on prostate) + Y022 (Therapeutic endoscopic implantation of prosthesis into prostate) which will group to the LB70 Complex Endoscopic, Prostate or Bladder Neck Procedures (Male and Female) HRG Root.

172. Annex A details the prices for LB70.

*Further information*

173. NICE has developed [medical technology guidance on prostatic urethral lift systems \(MTG26\)](#).<sup>48</sup>

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<sup>48</sup> [www.nice.org.uk/guidance/mtg26?unlid=](http://www.nice.org.uk/guidance/mtg26?unlid=)

## 4. Method for determining national prices

174. Our aim in setting prices is to support the highest quality patient care delivered in the most efficient way.

175. Our principles for setting national prices are that:

- a. Prices should reflect efficient costs. This means that the prices set should:
  - i. reflect the costs that a reasonably efficient provider ought to incur in supplying services at the quality expected by commissioners
  - ii. not provide full reimbursement for inefficient providers.
- b. Prices should provide appropriate signals by:
  - i. giving commissioners the information needed to make the best use of their budgets and enabling them to make decisions about the mix of services that offer most value to the populations they serve
  - ii. incentivising providers to reduce their unit costs by finding ways of working more efficiently
  - iii. encouraging providers to change from one delivery model to another where commissioners want this and where it is more efficient and effective.

### 4.1. Overall approach

176. We are setting national prices for 2017/18 and 2018/19.

177. We are setting prices using different methods for 2017/18 and 2018/19.

178. National prices for 2017/18 are modelled from the currency design set out in Section 3 of this document with 2014/15 costs and activity data. This is different from how we set the 2016/17 national prices, when we rolled over prices adopted under the Enhanced Tariff Option (ETO) with adjustments for cost uplifts, CNST and efficiency.<sup>49</sup> The methodology for the tariff model for the 2017/18 prices follows closely the methodology previously used by the DH Payment by Results (PbR) team.<sup>50</sup>

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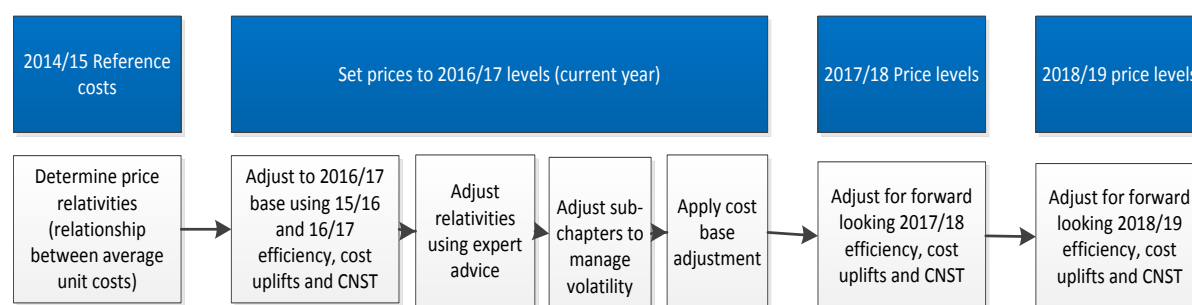
<sup>49</sup> More detail on the method used to set prices for 2015/16 can be found in Section 4 of the 2016/17 National Tariff Payment System [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/509697/2016-17\\_National\\_Tariff\\_Payment\\_System.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/509697/2016-17_National_Tariff_Payment_System.pdf)

<sup>50</sup> For a description of the 2013/14 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.

179. For 2018/19 we are using a rollover model. We use the 2017/18 national prices and currencies as a starting point and apply adjustments based on our estimates of inflation, efficiency and, where appropriate, CNST in 2018/19 to the 2017/18 prices to derive the 2018/19 prices. This is similar to the approach taken for the 2016/17 NTPS.

180. The stages in our approach can be seen below:

**Figure 1: Stages in our methods for setting national prices for 2017/19**



181. This section is supported by Annex B. This contains the models used to set prices:

- a. admitted patient care (APC) tariff model
- b. APC handbook
- c. outpatient procedures (OPROC) model
- d. outpatient attendances (OPATT) model
- e. accident and emergency (A&E) model
- f. unbundled services model
- g. maternity pathway model
- h. other national prices model
- i. best practice tariff (BPT) model.

182. The section below sets out a high level explanation of the method for setting prices and the changes made for this year. For the full detail of how each price has been set please consult the relevant model.

## 4.2. The method for setting prices

### 4.2.1. Modelling prices for 2017/18

183. We note that in adopting the PbR method for the 2017/18 tariff year we have in some cases deviated from the exact implementation of the method. For example we used different software packages for some calculations (SQL) than

those 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.

184. The PbR method for setting prices was different for different care settings (or points of delivery). This was mainly due to differences in the type of input data used and differences in assumptions and incentives. We have therefore developed a number of different models for different care settings (or procedures). This means that the 2017/18 tariff model is in practice a suite of tariff models (for example, we have separate models to generate APC and outpatient attendance (OPATT) prices).
185. The steps in our modelling approach for 2017/18 are:
- a. Determine price relativities (based on average unit costs). We use cleaned reference costs and Hospital Episode Statistics (HES) data as key inputs to set average costs per currency (eg HRG). See Sections 4.2.3 and 4.2.4 for more details.
  - b. Adjust average unit costs to an appropriate price base. As price relativities are based on 2014/15 costs we need to adjust them to the current year (2016/17) before we can make any forward-looking adjustments. To do this we adjust absolute price levels by applying efficiency, inflation and CNST adjustment factors for the two-year gap using the inflation and efficiency factors and, where appropriate, CNST from the 2016/17 national tariff. At this point we also apply an adjustment to the amount of money allocated to admitted patient care (a top slice) to be reallocated to top-up payments for specialised services (see Section 5.2).
  - c. Apply manual adjustments to modelled prices to reduce the number of instances where price relativities are implausible, illogical or distorted<sup>51</sup> (see Section 4.4).
  - d. Apply a cost base adjustment factor to prices to ensure prices reimburse a total amount of cost equal to the desired cost base, see Section 4.5.
  - e. Where appropriate, apply a volatility factor to prices (at subchapter level) to reduce volatility in prices. See Section 4.6.
  - f. Adjust prices to 2017/18 levels to reflect expected inflation (including service development), CNST (Section 4.7) and also an estimation of the level of efficiency that we expect they can achieve in 2017/18. See Section 4.8.

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<sup>51</sup> An example of an illogical relativity could be where the price for a more complex treatment is lower than the price for a less complex treatment without good reason.

186. The changes from the 2013/14 PbR method are to:

- a. update models for the HRG4+ currency design
- b. apply a small set of data-cleaning rules to the 2013/14 reference cost data to improve the quality of the cost data in the model
- c. include a reconciliation to ensure that we base our price relativities between tariff models on the equivalent cost relativities in the reference costs dataset
- d. make the manual adjustment process more transparent and included a reconciliation at chapter<sup>52</sup> level to ensure that the manual adjustments made to modelled prices do not change the total amount paid for each chapter
- e. make minor adjustments to streamline the calculation process and improve its transparency: for example removing some calculation steps in the 2013/14 PbR model which did not have any clearly identifiable policy intention (such as adjustments that appeared to be historic manual adjustments)
- f. recreate any models that were not transferred from DH as closely as possible
- g. update the calculation method for BPTs (Section 4.2.3)
- h. introduce volatility and a cost base adjustment (scaling)
- i. remove the affordability adjustment.<sup>53</sup>

187. For prices for which a 2013/14 PbR method was not available, we either:

- a. used the rollover approach applied in the 2014/15 national tariff (this approach calculates 2017/18 prices using the 2016/17 tariff prices as a base and applies the inflation, efficiency and, where applicable, CNST factors to them to arrive at the 2017/18 prices)<sup>54</sup>

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<sup>52</sup> In exceptional cases this was done at a subchapter level.

<sup>53</sup> Affordability remains a factor which is being considered - for example, when determining the appropriate efficiency factor, and when making decisions about cost base adjustments.

<sup>54</sup> 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).'



- b. developed new models that were designed to follow, as closely as possible, the principles of the 2013/14 PbR method: for example the calculation of the SSEM<sup>55</sup> tariff. All models can be found in Annex B.

#### **4.2.2. The rollover approach for 2018/19**

188. For 2018/19 we model prices using the 2017/18 price list as a base and then determine the final price levels by applying adjustments for expected efficiency, inflation and, where appropriate, CNST for 2018/19.

189. We have used the latest available projections to make these adjustments.

#### **4.2.3. Setting prices for best practice tariffs for 2017/18**

##### *Changes to the method for setting best practice tariffs*

190. For 2017/18 we have changed the method for setting prices for BPTs.

191. Where possible we have applied a standard method of pricing BPTs which can be summarised in three steps:

- a. using the modelled APC/OPROC or OPATT price (without BPT adjustments) as the starting point ('base price')
- b. setting a fixed differential between the BPT and non-BPT price. This differential can take the form of a percentage of the APC or OPATT base price or can be an absolute value
- c. setting the level of the BPT and non-BPT prices so that the BPTs are cost neutral at HRG level.

192. We set BPTs with the intention that they are cost neutral at HRG level. Under the DH PbR method neutrality was achieved by adjusting the overall uplift factor.

193. To achieve neutrality we need to make an assumption about the expected actual compliance rate, at an aggregate national level, for each HRG that is associated with a BPT in the tariff year (in this case 2017/18). If this is set too high, then it will create an extra efficiency ask on providers, too low and it will put extra pressure on commissioners. The compliance rates can be found in the BPT model in Annex B.

194. We currently do not have sufficient information to update the assumptions for the expected compliance rate in the 2017/18 tariff year for all BPTs. Where we do not have this information, we have used our best estimate for the expected 2017/18 compliance rates.

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<sup>55</sup> See 'Reduced short stay emergency tariff' in the BPT model in Annex B.

195. There are some BPTs where we are not fully able to implement the approach set out above. In those cases we developed bespoke solutions that either used the existing approach or streamlined the existing model as far as possible:

- a. Used the existing method (see Annex B and Annex F for more detail). We generally did this where we were not able to update either the 2013/14 PbR method and/or inputs to the 2013/14 PbR method. This affects:
  - i. early inflammatory arthritis
  - ii. major trauma
  - iii. paediatric diabetes year of care
  - iv. Parkinson's disease.
- b. Streamlined the existing model for that BPT, as far as possible, in line with the approach set out above, with necessary adjustments. In particular:
  - i. renal dialysis: maintaining the 2013/14 PbR method, except that we simplified the calculation of the peritoneal dialysis prices by basing them directly on reference costs
  - ii. paediatric epilepsy: setting the standard national price as per the 2013/14 PbR method and set the BPT based on the principles set out above
  - iii. pleural effusion: the currency design changed substantially for this BPT between 2013/14 and 2017/19 due to the introduction of HRG4+. We retained the policy intentions of the 2013/14 pleural effusion BPT design as much as possible, taking into account, where possible, the BPT simplification principles set out above
  - iv. transient ischaemic attack: we retained the extra payment as per the 2013/14 PbR method, but otherwise updated this BPT in line with the approach set out above.

196. All BPT price models can be found in Annex B.

#### **4.2.4. Changes to the method for calculating outpatient attendance prices**

197. To incentivise a change in the delivery of outpatient follow-up activity, to encourage a move to more efficient models of care (eg non face-to-face/telemedicine) and to free up consultant capacity, we over-reimburse first attendances and under-reimburse corresponding follow-up attendances. After calculating prices for these services we then make an adjustment to increase first attendances by a set percentage and reduce the corresponding follow-up price by the amount required to make up that increase. For example, if we increase the first attendance TFC by 10% and there is an average of two

follow-up attendances for this TFC, we would reduce the average follow-up price by 5%.

198. For 2017/19 we have increased this transfer for a number of TFCs from 10% to either 20% or 30%. There is a full list in Annex A.

### **4.3. Managing model inputs**

#### **4.3.1. Overall approach**

199. The two main data inputs used to generate prices for the 17/18 tariff year are costs (obtained from the annual reference cost collection) and activity, which is captured in the HES dataset as well as the annual reference cost collection. We explain these two datasets in more detail in this section.

200. For the 2018/19 tariff year, we are not using any activity and cost data to generate prices as the prices are based on the prices for the 2017/18 tariff year using a 'rollover' approach.

201. The reference costs dataset contains cost and activity data for many, but not all, healthcare services providers. The data are collected from all NHS trusts and NHS foundation trusts and therefore cover most healthcare costs. We do not currently collect cost data from the independent sector.

202. The HES activity dataset contains the number of admitted patient care, outpatient appointments and A&E attendances in England from all providers of secondary care services to the NHS. It is mainly needed for the APC tariff calculation because the APC currencies are paid on a spell basis, while the activity data contained in the reference cost dataset are based on FCEs.

203. We are using 2014/15 reference costs and 2014/15 activity data to model prices for the 2017/18 tariff year.

#### **4.3.2. Reference cost inputs**

##### *Reference cost dataset used*

204. We are using 2014/15 reference cost data<sup>56</sup> for the prices for the 2017/18 tariff year. We use this reference cost dataset because it is very closely aligned with the currency design<sup>57</sup> of the 2017/19 tariff.

##### *Reference cost data cleaning*

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

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<sup>56</sup> See [NHS reference costs 2014 to 2015](#).

<sup>57</sup> We have used the HRG4+ currency system (see Section 4 of this document for further details).

206. We think using cleaned data (ie raw reference cost data with some 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).<sup>58</sup> This, in turn, should reduce the number of modelled prices that require manual adjustment and should therefore increase the reliability of the tariff. We believe this benefit outweighs the disadvantage of losing some data points as a result of the data cleaning process.
207. We have applied new rules for reference cost data cleaning based on recommendations provided by Deloitte.<sup>59</sup> These exclude:
- a. 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’)
  - b. providers that submitted reference costs more than 50% below the national average for more than 25% of HRGs and at the same time also submitted reference costs 50% higher than the national average for more than 25% of HRGs submitted
  - c. providers who submitted reference costs containing more than 75% duplicate costs across HRGs and departments.
208. We have not followed the recommendations in full because we encountered some technical issues in implementing 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:
- a. 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
  - b. exclude providers who submitted reference costs containing more than 15% of unit costs that exhibited illogical relativities.
209. For the prices in the 2017/18 tariff year we are cleaning only reference cost data for the model for APC.
210. Applying these rules to the reference costs dataset we use to set national prices for APC 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

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<sup>58</sup> An illogical relativity is where the cost of performing a more complex procedure is lower than the cost of performing a less complex procedure (without good reason).

<sup>59</sup> See the independent research paper on the ‘[NHS National Tariff Payment System 2016/17: engagement documents](#)’ webpage.

remove all APC reference cost data submitted by six, mainly mental health and community, providers.

#### 4.3.3. HES data inputs

211. We use 2014/15 HES data grouped by NHS Improvement using the 2014/15 (HRG4+) various groupers and the 2017/18 engagement grouper in our modelling of the prices for the 2017/18 tariff year.
212. Using NHS Improvement grouping is a deviation from the 2013/14 PbR method which used HES data grouped by NHS Digital. However, we are making this change because:
- a. it allows us more flexibility in the timing of grouping the data
  - b. NHS Digital uses patient-identifiable data for grouping, which cannot be shared with third parties (to protect patient confidentiality). NHS Improvement's method does not use patient-identifiable data, which makes it easier for third parties to replicate our method. We believe this change makes the tariff more transparent and will enable stakeholders to better review and engage with our proposed tariff calculation method.
213. The NHS Improvement grouping method aims to follow, as closely as possible, the casemix grouping method, and initial analysis indicates that the differences between the two grouping methods are relatively small.

#### 4.3.4. Updates to the maternity pathway

214. For maternity, price relativities are set using assumptions about the casemix. We have updated the casemix assumptions for the antenatal phase of the maternity pathway model. These changes are based on feedback from clinicians.
215. As a result of this information, we updated our model inputs to assume that more women will require intermediate and intensive antenatal care. Our revised assumptions are shown in Table 8.

**Table 8: Assumptions for antenatal care**

Pathway	PbR allocations	2017/18 allocations
Standard	64.0%	50.0%
Intermediate	28.2%	38.7%
Intensive	7.8%	11.3%

216. Full details of the method for setting prices for maternity are in Annex B.

#### 4.4. Manual adjustments

217. The 2013/14 PbR method involved making some manual adjustments to the modelled tariff. This was done to minimise the risk of setting implausible tariffs (eg tariffs that have illogical relativities) based on reference cost data of variable quality. We have broadly followed this approach for the 2017 to 2019 national tariff. We have also introduced a new process of making manual adjustments to price relativities as they are published. This involved not identifying illogical relativities but identifying implausible prices from a clinical perspective. In doing so we adopted the following process.

- a. We made manual adjustments following feedback on draft tariff prices:
  - i. We made several manual adjustments following a series of meetings to review draft price relativities with NHS Digital's expert working groups of clinicians before publication of the currency design and relative prices engagement document released in August 2016.
  - ii. We made further manual adjustments and revisions following stakeholder feedback and comments, further engagement with clinical experts and adjustments on the draft prices published in this summer engagement document.

218. The manual adjustments made to individual prices can be found in Annex B.

#### 4.5. Cost base

219. The cost base is the level of cost that the tariff will allow providers to recover before adjustments are made for cost uplifts and the efficiency factor is applied.

220. For 2017/18 and 2018/19, for the total activity with a national price, we have set the cost base equal to the revenue that would be received under 2016/17 national tariff. In other words, we have made no adjustment to the cost base, except for that which recognises changes in the scope of nationally priced services.

221. As with many other parts of tariff setting, we used last year's tariff as a starting point for the following tariff. Therefore, last year's prices and last year's revenue are used as a starting point.

222. After setting the starting point, we consider new information, and a number of factors to form a view of whether an adjustment to the cost base is warranted.

223. Information and factors we considered include:

- a. historical efficiency and cost uplift assumptions
- b. latest cost data

- c. additional funding outside the national tariff
- d. any other additional revenue providers use to pay for tariff services<sup>60</sup>
- e. our pricing principles and the factors which legislation requires us to consider, including matters such as the importance of setting cost-reflective prices, and the need to take into account the duties of commissioners in the context of the budget available for the NHS.

224. In using our judgement, we also consider the effect of setting the cost base too high or too low. This effect is asymmetric:

- a. If we set the cost base too low (ie we set too high an expectation that providers will be able to catch up to past undelivered efficiency), providers will be in deficit, service quality will decrease (eg waiting times will increase), and some providers may cease providing certain services.
- b. However, if we set the cost base too high, commissioners, who have an obligation to stay within their budgets, are likely to restrict the volumes of commissioned services, and could cease commissioning certain services entirely. This would mean some patients may not be provided with the healthcare service they require.

225. Given the above, it is our judgement to keep the cost base equal to the revenue that would be received under 2016/17 prices.

#### 4.6. Volatility

226. To reduce the volatility from introducing a new currency design we have adjusted prices in some subchapters such that services recover 75% of the initial estimated loss. Tariff prices outside these subchapters have been top-sliced to pay for this revenue adjustment. Table 9 displays the adjustments factors.

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<sup>60</sup> We commissioned a review into the cost base from FTI. This can be found at: [improvement.nhs.uk/resources/national-tariff-1719-consultation](https://improvement.nhs.uk/resources/national-tariff-1719-consultation)

**Table 9: Subchapters and uplift adjustments**

Subchapter	Subchapter description	Uplift adjustment
HC	Spinal Procedures and Disorders	3.9%
HD	Musculoskeletal and Rheumatological Disorders	0.9%
HE	Orthopaedic Disorders	11.1%
HN	Orthopaedic Non-Trauma Procedures	5.3%
HT	Orthopaedic Trauma Procedures	7.9%
LD	Renal Dialysis for Chronic Kidney Disease	10.4%
PB	Neonatal Disorders	15.0%
SB	Chemotherapy	4.1%
SC	Radiotherapy	6.3%
	All remaining chapters	-1.2%

#### 4.7. Cost uplifts

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

228. We have retained broadly the same methodology for 2017/18 and 2018/19 as for 2016/17 with some developments as discussed below. We recognise that forecasting inflation for two years is subject to increased uncertainty but we have used the best available information.

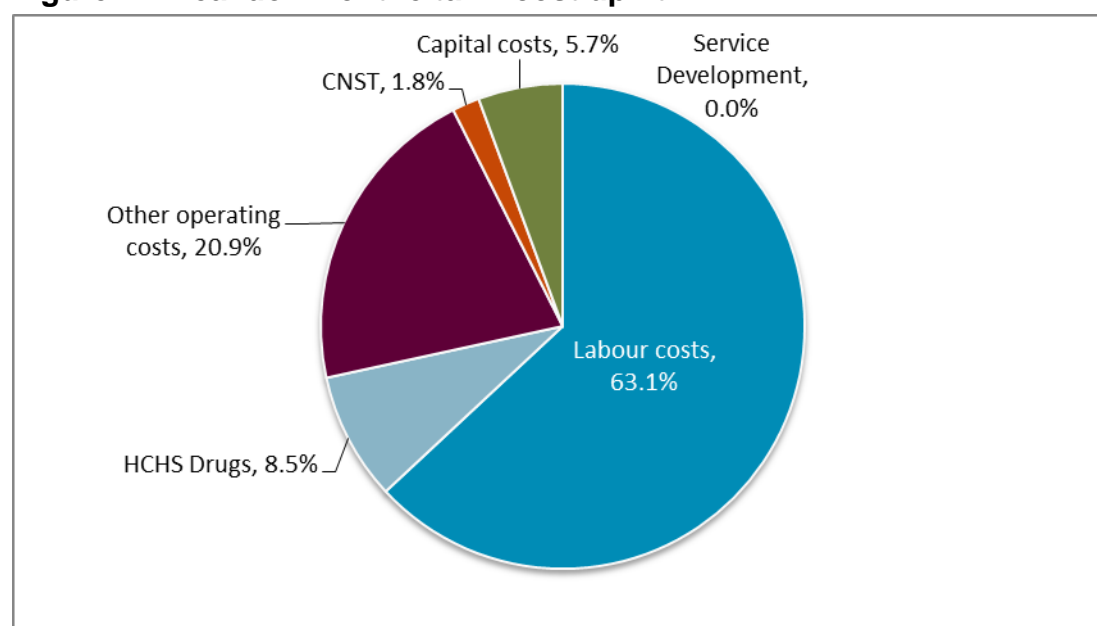
229. In determining the cost uplift adjustments we have considered six categories of cost pressures. These are:

- a. pay costs
- b. drugs costs
- c. other operating costs
- d. changes in the cost associated with CNST payments
- e. changes in capital costs (ie changes in costs associated with depreciation and private finance initiative payments)
- f. costs arising from new requirements in the mandate to NHS England. We call these changes 'service development' costs. There are no adjustments from the mandate for service development in 2017/18 or 2018/19.



230. The adjustments are included in a total cost uplift factor which is then applied to the modelled or rolled-over prices, except, as explained below, for most of the CNST increases. In setting the general cost uplift factor, each cost category is assigned a weight reflecting the proportion of total expenditure. These weights are based on aggregate provider expenditure obtained from DH's published 2015/16 financial accounts. Figure 2 shows the weights applied to each cost category.

**Figure 2: Breakdown of the tariff cost uplift**



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

### *Pay*

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

233. Pay-related inflation has four elements. These are:

- a. pay settlements: the increase in the unit cost of labour reflected in pay awards for the NHS
- b. pay drift: the tendency for staff to move to a higher increment or to be upgraded and also includes the impact of overtime
- c. staff group mix: 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)

- d. extra overhead labour costs: there are two new charges for NHS providers, the apprenticeship levy and the immigration skills charge, both due to be implemented from 1 April 2017.
234. We are using DH's central estimates for these components. DH maintains the most accurate and detailed records of labour costs in the NHS, and is directly involved in pay negotiations. We are assuming pay drift and group mix effects of 0.7% in 2017/18 and 1.0% in 2018/19. In arriving at these figures, an adjustment of -0.3% has been made to the DH projections for pay drift and staff mix to reduce or exclude elements of pay inflation that lead to extra output and thus are remunerated through activity rather than price.
235. The pay award is in line with public sector pay policy of 1% and this is assumed to be the same for both 2017/18 and 2018/19. The 1% pay award assumption is a limit to the average pay award set by HM Treasury. A greater increase for lower paid staff would have to be offset by a lower increase for higher paid staff.
236. The combined impact of pay drift and group mix for tariff purposes is assumed to be 0.7% in 2017/18 and 1.0% in 2018/19.
237. The apprenticeship levy is estimated to add a net 0.3% to the total wage bill in 2017/18 (with no further impact in 2018/19). This comprises 0.4% expected gross costs, offset by 0.1% financial benefit, as employers can access funding for the training of apprentices.
238. The immigration skills charge is estimated to add 0.1% to the total wage bill in 2017/18 (with no further impact in 2018/19).
239. In total, the projection is an increase in the pay bill of 2.1% in 2017/18 and 2.1% in 2018/19.

#### *Drugs costs*

240. The drugs cost uplift is intended to reflect increases in drugs expenditure per unit of activity. Although drugs costs are a relatively small component of total provider expenditure (approximately 8%), they have historically grown faster than other costs. This has made drugs costs one of the larger cost uplift components in some years.
241. Our approach is a development of that used in previous years which uses a forecast increase in expenditure and removes the increase in costs resulting from activity to identify the cost increase due to price increases. This is because providers will be paid for increased drugs use because of the increase in volumes and therefore payments. We have also made a new adjustment to seek to exclude the impact of the more rapid forecast of price growth in high cost drugs paid for on a pass-through basis outside of tariff. As the cost of these

drugs is remunerated outside the tariff, it is not correct to include it in our calculation of tariff inflation.

242. To reflect the expected increase in drugs costs, we have used DH's estimates as the basis for our calculation. This estimate is based on long-term trends and DH's expectation of new drugs coming to market, and other drugs that will cease to be provided solely under patent in the coming 12 months. DH has provided us with its best estimate of the increase in drugs total costs for providers. The figures are 5.8% in 2017/18 and 5.0% in 2018/19. We then adjust these by:

- calculating a revised figure for tariff drugs, by assuming 6.2% cost growth in the proportion of drugs expenditure accounted for by pass-through drugs. This figure is based on the NHS England analysis of likely expenditure growth in high cost drugs (9% average growth) less an assessment of overall efficiencies required of specialised commissioning (2.6%)<sup>61</sup>
- removing assumed underlying activity growth of 2.5% in both years as increases in activity are covered by each additional unit paid for, not increases in price per unit
- recognising the uncertainty associated with these adjustments, particularly for pass through drugs, setting the growth figure to be at least the gross domestic product (GDP) deflator estimated by the Office for Budget Responsibility (OBR) each year.

243. This results in assumed drugs cost inflation of 2.8% in 2017/18 and 2.1% in 2018/19.

#### *Other operating costs*

244. 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 OBR as the basis of the expected increase in costs. The GDP deflator, from June 2016,<sup>62</sup> is 1.8% in 2017/18 and 2.1% in 2018/19. In both years this translates to a 0.4% uplift once the weighting of the increase is taken into consideration.<sup>63</sup>

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<sup>61</sup> Note that the percentages do not sum due to compounding effects.

<sup>62</sup> Published at [www.gov.uk/government/statistics/gdp-deflators-at-market-prices-and-money-gdp-june-2016-quarterly-national-accounts](http://www.gov.uk/government/statistics/gdp-deflators-at-market-prices-and-money-gdp-june-2016-quarterly-national-accounts)

<sup>63</sup> To be consistent with other model inputs we used the latest available figure at the time of price modelling. Changes to inputs after this point would have had an impact on financial planning.

## *Clinical Negligence Scheme for Trusts*

245. The Clinical Negligence Scheme for Trusts (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.<sup>64</sup> 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.
246. Following the previous DH approach, we have allocated the increase in CNST costs to core HRG subchapters, to the maternity delivery tariff and A&E services in line with the average cost increases that will be paid by providers. This approach to the CNST uplift is different to other cost uplifts. While other cost uplifts are estimated and applied across all prices, the estimate of the CNST cost increase differs according to the mix of services delivered by providers. To reflect these differences in CNST payments, the cost uplift is differentially applied across HRG subchapter, A&E services and for the maternity delivery tariff. Each relevant HRG is uplifted based on the change in CNST cost across specialties mapped to HRG subchapters. This means that our cost uplifts reflect, on average, each provider's relative exposure to CNST cost growth, given their individual mix of services and procedures.<sup>65</sup>
247. Table 10 lists the percentage uplift that we have applied to each HRG subchapter to reflect the increase in CNST costs.
248. Most of the increases in CNST costs are allocated at HRG subchapter level, maternity tariff or A&E, but a small residual amount (about £18 million in 2017/18 and £22.1 million in 2018/19) is unallocated at a specific HRG level. This unallocated figure is redistributed as a general uplift across all prices. We have calculated the uplift due to this pressure as 0.02% in both 2017/18 and 2018/19 (though this is given as 0.0% in Table 10 due to rounding).

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<sup>64</sup> CCGs and NHS England are also members of the CNST scheme.

<sup>65</sup> For example, maternity services have been a major driver of CNST costs in recent years. For this reason, a provider delivering maternity services as a large proportion of its overall service mix would probably find that its CNST contributions (set by NHSLA) have increased more quickly than the contributions of other providers. However, the cost uplift reflects this, since the CNST uplift is higher for maternity services. This is consistent with the approach previously taken by DH.

**Table 10: CNST tariff impact by HRG subchapter**

HRG sub chapter	2017/18 up lift (%)	2018/19 uplift (%)	HRG sub chapter	2017/18 uplift (%)	2018/19 uplift (%)	HRG sub chapter	2017/18 uplift (%)	2018/19 uplift (%)
AA	0.72%	0.89%	JC	0.67%	0.80%	PP	1.25%	1.53%
AB	0.41%	0.54%	JD	0.40%	0.49%	PQ	0.58%	0.71%
BZ	0.54%	0.68%	KA	0.48%	0.63%	PR	1.14%	1.41%
CA	0.34%	0.46%	KB	0.22%	0.25%	PV	1.08%	1.34%
CB	0.36%	0.45%	KC	0.20%	0.22%	PW	1.33%	1.62%
CD	0.16%	0.19%	LA	0.18%	0.20%	PX	1.10%	1.35%
DZ	0.17%	0.20%	LB	0.37%	0.45%	SA	0.30%	0.37%
EB	0.26%	0.31%	MA	0.22%	0.37%	VA	0.83%	1.08%
EC	0.26%	0.33%	MB	0.41%	0.58%	WH	0.49%	0.61%
ED	0.23%	0.32%	PB	1.12%	1.38%	WJ	0.22%	0.26%
EY	0.29%	0.36%	PC	1.18%	1.45%	YA	2.71%	3.55%
FZ	0.56%	0.71%	PD	1.33%	1.63%	YD	0.29%	0.33%
GA	0.56%	0.72%	PE	0.94%	1.15%	YF	0.57%	0.73%
GB	0.27%	0.34%	PF	1.14%	1.40%	YG	0.26%	0.31%
GC	0.52%	0.65%	PG	0.75%	0.92%	YH	0.91%	1.17%
HC	0.84%	1.10%	PH	0.86%	1.07%	YJ	0.72%	0.92%
HD	0.49%	0.60%	PJ	1.24%	1.51%	YL	0.23%	0.28%
HE	1.51%	1.92%	PK	0.74%	0.91%	YQ	0.71%	0.91%
HN	0.83%	1.08%	PL	0.79%	0.97%	YR	0.75%	0.95%
HT	0.92%	1.20%	PM	0.24%	0.30%	VB	1.94%	1.90%
JA	0.84%	1.05%	PN	0.70%	0.85%	Maternity	6.36%	7.54%

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

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

249. Providers' costs typically include depreciation charges and PFI payments. As with increases in operating costs, providers should have an opportunity to recover an increase in these capital costs.
250. In previous years, DH reflected changes in these capital costs when calculating cost uplifts, and we have adopted the same approach for 2017/18 and 2018/19. Specifically, we have applied DH's projection of changes in overall depreciation charges and PFI payments.
251. In aggregate, DH projects PFI and depreciation costs to grow by 3.0% in 2017/18 and 2.9% in 2018/19. These both translate to a 0.2% uplift on tariff prices.

*Service development*

252. The service development uplift factor reflects the expected extra unit costs to providers of major initiatives that are included in the Mandate.<sup>66</sup> There are no major initiatives anticipated in the Mandate to be funded through national prices in 2017/18 or 2018/19, and no uplift is to be applied for either year.

#### 4.7.2. Summary of data for cost uplifts

253. Given the above, we have calculated the total cost uplift factor for both 2017/18 and 2018/19 national prices as 2.1%, as shown in Table 11. This excludes the targeted CNST adjustments.

**Table 11: Cost uplift factors**

Uplift factors	Weighted average estimate (uplift x weighting)	
	2017/18	2018/19
Pay costs	1.3%	1.3%
Drugs costs	0.2%	0.2%
Other operating costs	0.4%	0.4%
Unallocated CNST	0.0%	0.0%
Capital costs	0.2%	0.2%
<b>Total</b>	<b>2.1%</b>	<b>2.1%</b>

Notes: Unallocated CNST refers to CNST cost increases not associated with specific HRG subchapters. Numbers may not add up exactly due to rounding.

<sup>66</sup> The mandate to NHS England sets out objectives for the NHS and highlights the areas of health care where the government expects to see improvements.

## 4.8. Efficiency

254. The efficiency factor for 2017/18 is 2%. The efficiency factor for 2018/19 is also 2%.

255. We use evidence-based data to set the efficiency factor. As a starting point we use the Deloitte analysis produced to inform us on the efficiency factor for the 2015/16 national tariff. The initial analysis was based on an econometric model and a supporting case study.<sup>67</sup> The model used data from 165 acute trusts for the period between the 2008/09 and 2012/13 financial years. For the 2016/17 national tariff we developed further the Deloitte's econometric model by changing our measurement of some variables and by incorporating 2013/14 data into the model.<sup>68</sup>

256. For the 2017/18 national tariff we considered more ways in which we might develop the existing econometric model, as well as whether any update to the evidence was needed. We have decided to update the 2016/17 analysis to include 2014/15 data.<sup>69</sup> This allows us to account for the most recent changes in efficiency in our decision on the efficiency factor setting. We have also improved the measurement of deprivation in the model.<sup>70</sup>

257. Our modelling suggests that trusts become 1% more efficient each year on average. Around this trend we estimate that there is substantial variation in efficiency, which could justify an efficiency factor greater than 1% as poorer performers can improve more than the average. For instance, if the average performer catches up to the 60<sup>th</sup> centile we estimate that this would release 1.6% efficiency in addition to trend efficiency. Given the financial pressures on the NHS, we believe that it is appropriate to set a challenging but achievable efficiency factor for 2017/18. We are proposing an efficiency factor of 2%.

258. For 2018/19 we assume trend efficiency will continue and this is in line with the other government reviews.<sup>71</sup> Given that the financial pressures on the NHS are likely to continue, we again consider it appropriate to set a challenging but achievable efficiency factor. We therefore consider it appropriate to adopt an efficiency factor of 2% for 2018/19.

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<sup>67</sup> See [Deloitte report](#) for detailed description of the method.

<sup>68</sup> The report of the efficiency factor for the 2016/17 national tariff can be found here: [Evidence on the efficiency factor](#).

<sup>69</sup> Where changes in data collections mean data is no available for variables, for instance, certain disease's prevalence in the Quality Outcomes Framework, we have extrapolated based on historical data.

<sup>70</sup> In 2016/17 the estimate of the level of deprivation a trust faced was calculated using the area-level index of multiple deprivation, mapped to trusts by the average patient flow. This was time-invariant. This year we have recalculated patient flow each year. This enables us to capture changes in the deprivation profile a trust may face due to changes in catchment area served over time.

<sup>71</sup> A recent [Carter review report](#) on operational productivity and performance suggests the NHS is expected to deliver efficiencies of 2% to 3% per year, which could represent savings of 10% to 15% by 2021.

## 5. National variations to national prices

259. In some circumstances, it is appropriate to make national adjustments to national prices. For example, adjustments may reflect local differences in costs that the formulation of national prices has not taken into account, or share risk more appropriately among parties.

260. 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'.

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

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

262. This section sets out the national variations specified in the 2017/19 NTPS.

263. The national variations have changed from those set out in the 2016/17 NTPS in one area, top-ups for specialised services. All other national variations remain the same.

264. National variations are an important part of the overarching payment system framework. They sit alongside local variations and local modifications. Providers and commissioners should note that:

- a. National variations only apply to services with a national price.
- b. If a commissioner and a provider choose to bundle services that have a mix of national prices and locally determined prices, national variations can in effect be disappplied or modified by local variations agreed in accordance with the applicable rules (see Section 6.2).
- c. In the case of an application or agreement for a local modification (see Section 6.3), the analysis must reflect all national variations that could alter the price payable for a service (ie it is the price after any national variations have been applied that should be compared with a provider's costs).
- d. Where a new service is commissioned that does not have a national price, rules for local price-setting apply (see Section 6.4).



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

- a. variations to reflect regional cost differences
- b. variations to reflect patient complexity
- c. variations to help prevent avoidable hospital stays
- d. variations to support transition to new payment approaches.

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

266. 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.

267. 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 is constructed to always have 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).

268. Further information on the calculation and application of the MFF is provided in the supporting guidance document, [A guide to the market forces factor](#).

269. The 2016/17 MFF indices remain unchanged for 2017 to 2019, except in cases where organisations have merged or are merging or are undergoing some other organisational restructuring (such as dissolution) before 1 April 2017. The MFF index values for each NHS provider are in Annex A.

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

271. Organisations merging or undergoing other organisational restructuring after 31 March 2017 will not have a new MFF set during the period covered by the tariff.

For further guidance in these circumstances see the supporting document, [A guide to the market forces factor](#)

272. Where there is a relevant acquisition or merger prior to 31 March 2017 a new MFF will be calculated and will apply from 1 April 2017. Providers should notify NHS Improvement by email ([pricing@improvement.nhs.uk](mailto:pricing@improvement.nhs.uk)) of any planned changes that might affect the MFF index.

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

273. 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 HRG design. Only a few providers are commissioned to provide such care.
274. To set payments we make an adjustment (a top-slice) to the total amount of money allocated to national prices and reallocate this money to providers of specialised services.
275. Specialised service top-ups have been part of the payment system since 2005/06. The current list of qualifying specialised services, and the design and calculation of specialised top-ups for these services, are informed by research undertaken in 2011 by the Centre for Health Economics at the University of York.<sup>72</sup>
276. These amounts paid and the providers that are eligible are based on the prescribed specialised services (PSS) definitions provided by the NHS England specialised commissioning team. The list of eligible providers is contained within the PSS operational tool.<sup>73</sup>
277. Top-up payments are only made for inpatient care.

**Table 12: Top-up impact by specialist area 2017/19**

Top-up area	Top-up amounts £m
All top-up areas	478.5m
Spinal	13.9m
Neurosciences	117.7m
Orthopaedics	4.2m

<sup>72</sup> [Estimating the costs of specialised care](#) and [Estimating the costs of specialised care: updated analysis using data for 2009/10](#).

<sup>73</sup> <http://content.digital.nhs.uk/casemix/prescribedspecialisedservices>

Top-up area	Top-up amounts £m
Children	209.6m
Cancer	16.7m
Respiratory	32.3m
Cardiac	73.3m
Other	10.7m

278. We have changed the top-ups payable for 2017 to 2019 based on these definitions to introduce payments for new areas including cancer, respiratory and cardiac care.

279. A list of the services eligible for top-ups, the adjustments and their flags can be found in Annex A.

### 5.3. Variations to help prevent avoidable hospital stays

#### 5.3.1. Marginal rate emergency rule

280. 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.<sup>74</sup> It was made up primarily of emergency spells lasting less than 48 hours.

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

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

282. The marginal rate emergency rule sets a baseline monetary value (specified in GBP) for emergency admissions at a provider.<sup>75</sup> A provider is then paid 70% of the national price for any increases in the value of emergency admissions above this baseline. Further guidance for commissioners on investing retained funds can be found [on our website](#).<sup>76</sup>

283. While the original design of the marginal rate emergency rule set a national baseline expectation, our review of the policy in 2014/15 identified that in some

<sup>74</sup> Over 70% of emergency admissions are patients who are admitted following an attendance at A&E.

<sup>75</sup> 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).

<sup>76</sup> [improvement.nhs.uk/resources/national-tariff-1719-consultation](http://improvement.nhs.uk/resources/national-tariff-1719-consultation)

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 insufficient progress towards demand management and discharge management schemes. In 2014/15 we therefore updated the marginal rate emergency rule to:

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

284. The rule continues to include the changes to local baseline setting and reinvestment transparency introduced in 2014/15.

#### *Setting and adjusting the baseline*

285. A provider's total baseline value must be assessed as the value of all emergency admissions at the provider in 2008/09 according to the relevant year's NTPS prices (2017/18 or 2018/19).<sup>77</sup> A contract baseline value must be calculated for each contractual relationship.

286. We recognise that changes to HRGs since 2008/09 and the introduction of BPTs<sup>78</sup> 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.

287. 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. Examples of relevant changes to consider include:

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

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<sup>77</sup> Some emergency activity is excluded from the marginal rate rule and should not be included in the calculation of baseline values, including: activity that does not have a national price, non-contract activity, activity covered by BPTs (except for the BPT that promotes same-day emergency care), A&E attendances, outpatient appointments, and contracts with commissioners falling in responsibility of devolved administrations.

<sup>78</sup> Activity reimbursed by BPTs is not subject to the marginal rate, with the exception of the BPT for same-day emergency care.

- c. 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.

288. Making local adjustments may therefore be necessary to ensure a balance between maintaining 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.

289. 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 the reduction of a nearby hospital's A&E department opening hours will be considered a change outside the control of the provider and so 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 provider's A&E department will not necessitate an adjustment to the baseline.

290. When assessing supply and demand for emergency admissions, commissioners should consider the factors set out in Table 13.

**Table 13: 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 <sup>79</sup>
	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 <sup>80</sup>	No, unless this reflects a change in commissioning patterns

<sup>79</sup> We expect commissioning patterns to reflect best clinical practice, including where this results in the decommissioning of 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).

<sup>80</sup> We recognise that establishing a definitive change to clinical practice may be difficult. We suggest that providers and commissioners examine available data; for example, any trends in the casemix

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

291. When calculating baseline values, both increases and decreases in the value of activity should be considered equally according to the criteria in Table 11.
292. 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.
293. The agreed baseline value (specified in £s) must be explicitly stated in 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.
294. Acute providers or other parties in the local health economy should raise any concerns about baseline agreements with NHS England, through its local offices. Where local consensus cannot be reached, the local NHS England office will provide mediation, in the context of NHS England's CCG assurance role, to ensure CCG plans are consistent with this guidance. Where necessary, NHS Improvement and NHS England will consider enforcing the rules set out in this guidance through their enforcement powers. Where the local NHS England office is the commissioner, the NHS England regional team will provide mediation. In all cases, NHS Improvement must be notified (via [pricing@improvement.nhs.uk](mailto:pricing@improvement.nhs.uk)) where concerns have been raised, and whether (and how) plans were changed as a result.

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

### *Application of the rule*

295. The marginal rate rule is applied individually to any contractual relationship. It is applied to any contract where the value of emergency admissions has increased above the baseline value for that contract.
296. 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<sup>81</sup> 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.
297. The marginal rate emergency rule 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.
298. The marginal rate emergency rule does not apply to:
- a. activity which does not have a national price
  - b. non-contract activity
  - c. activity covered by BPTs, except for the BPT for same-day emergency care<sup>82</sup>
  - d. A&E attendances
  - e. outpatient appointments
  - f. contracts with commissioners falling within the responsibility of devolved administrations.

### **5.3.2. Emergency readmissions within 30 days**

299. To provide the most suitable care for patients when they leave hospital, providers need robust discharge planning arrangements. Planning may include

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<sup>81</sup> A small contract is one where the baseline value is less than 5% of the provider's total baseline value across all contracts.

<sup>82</sup> 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.

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.

300. 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. It 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.
301. We have retained this national variation. The rest of this section defines an emergency readmission for the purpose of the readmission rule and sets out how the rule should be applied. Further guidance for commissioners on investing retained funds can be found [on our website](#).<sup>83</sup>

*Definition of an emergency readmission*

302. An emergency readmission is any readmission that:<sup>84</sup>
- a. happens up to 30 days from discharge from initial admission
  - b. has an emergency admission method code<sup>85</sup>
  - c. has a national price.
303. 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 to withhold payment. Commissioners should continue to pay providers for readmitted patients when any of these exclusions apply. The excluded readmissions are:
- a. any that do not have a national price
  - b. maternity and childbirth<sup>86</sup>
  - c. cancer, chemotherapy and radiotherapy<sup>87</sup>

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<sup>83</sup> <https://improvement.nhs.uk/resources/national-tariff-1719-consultation>

<sup>84</sup> 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.

<sup>85</sup> As defined in the [NHS Data Model and Dictionary](#).

<sup>86</sup> Where the initial admission or readmission is in HRG subchapter NZ (obstetric medicine).



- d. patients receiving renal dialysis
- e. patients readmitted after an organ transplant
- f. young children (under four years old at the time of readmission)
- g. patients who are readmitted having self-discharged against clinical advice<sup>88</sup>
- h. emergency transfers of an admitted patient from another provider, where the admission at the transferring provider was an initial admission<sup>89</sup>
- i. cross-border activity where the initial admission or readmission is in Northern Ireland, Scotland or Wales.

### *Application of the rule*

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

- a. undertake a clinical review of a sample of readmissions. Providers and commissioners are not required to undertake a clinical review where there continues to be local agreement on the readmissions threshold
- b. set an agreed threshold (informed by the clinical review), above which readmissions will not be paid
- c. determine the amount that will not be paid for each readmission above the threshold.

### *Step 1 clinical review*

305. 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.<sup>90</sup>

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<sup>87</sup> Where the initial admission or readmission includes a spell first mentioned or primary diagnosis of cancer (ICD-10 codes C00-C97 and D37-D48) or an unbundled HRG in subchapter SB (chemotherapy) or SC (radiotherapy).

<sup>88</sup> Included in discharge method code 2 in the initial admission.

<sup>89</sup> 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.

<sup>90</sup> 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 them even if there is a possibility of an emergency readmission occurring within 30 days of discharge.

306. 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.<sup>91</sup>
307. For each patient in the sample, the review team should decide whether the readmission could have been avoided through actions the provider, the primary care team, community health services or social services, or a body contracted to any of these organisations might have taken.<sup>92</sup>
308. 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*

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

### *Step 3 determining the amount that will not be paid*

310. 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,<sup>93</sup> including any associated unbundled costs, such as critical care or high cost drugs.
311. Where a patient is readmitted to a different provider (from that of initial admission), the second provider must be paid. However, the commissioner will deduct an amount from the first provider.<sup>94</sup>

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<sup>91</sup> More information can be found on NHS Digital's information governance website. [systems.digital.nhs.uk/infogov](https://systems.digital.nhs.uk/infogov)

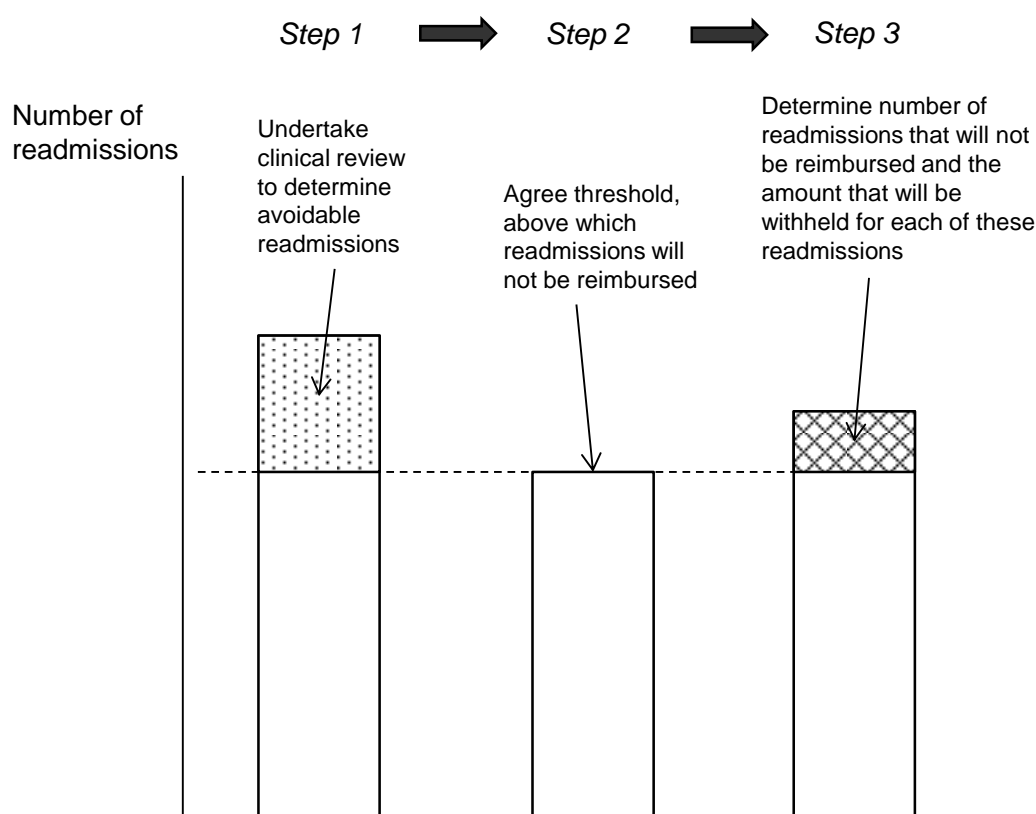
<sup>92</sup> The King's Fund paper *Avoiding hospital admissions – what does the research evidence say?* illustrates some examples of interventions which are more likely and less likely to succeed in reducing readmissions.

<sup>93</sup> The spell in this context includes all care between admission and discharge, regardless of any transfers.

<sup>94</sup> 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.

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

**Figure 3: Implementing the emergency readmissions rule**



#### 5.4. Variations to support transition to new payment approaches

313. New or changing payment approaches can alter provider income or commissioner expenditure. For some organisations, the financial impact can be significant and could be difficult to manage in one step.

##### 5.4.1. Best practice tariff for primary hip and knee replacements

314. Section 4 sets out details of the primary hip and knee replacement BPT introduced in 2014/15 to promote improved outcomes for patients.

315. 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 the best practice criteria, but where it would be inappropriate not to pay the full BPT price. These circumstances are:

- a. when recent improvements in patient outcomes are not yet reflected in the nationally available data
- b. when providers have identified why they are an outlier on patient reported outcome measures (PROMs) scores and have a credible improvement plan in place, the impact of which is not yet known
- c. when a provider has a particularly complex casemix that is not yet appropriately taken into account in the casemix adjustment in PROMs.

316. Under this national variation, commissioners must pay the full BPT if the provider can show that any of the above circumstances apply. The rationale for using a variation in these three circumstances is explained below.

#### *Recent improvements*

317. 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*

318. 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 providers not meeting the payment criteria.

319. In this situation, the variation would be a time-limited agreement. Published data would need to show improvements for payment at the BPT level to continue.

320. There are many factors that may affect patient outcomes, and it is for local providers and commissioners to decide how to achieve improvements but the following suggestions may be useful:

- a. Headline PROMs scores can be broken down into individual domain scores. If required, providers can also request access to individual patient scores through NHS Digital. Providers might look at the questions on which they score badly to see why they are an outlier: for example, those relating to pain management.
- b. Individual patient outcomes might also be compared with patient records to check for complications in surgery or comorbidities that may not be accounted for in the formal casemix adjustment. It would also be sensible to check whether patients attended rehabilitation sessions after being discharged from hospital.

- c. Reviewing the surgical techniques and prostheses used against clinical guidelines and National Joint Registry recommendations is another way providers might try to address poor outcomes. As well as improving the surgical procedure itself, providers could scrutinise the whole care pathway to improve patient outcomes by ensuring that weakness in another area is not affecting patient outcomes after surgery.
- d. Providers may also choose to collaborate with others that have outcomes significantly above average to learn from their service design. Alternatively, they might do 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*

321. Providers that have a particularly complex casemix and cannot show they meet the best practice criteria may request that the commissioner continues to pay the full BPT. Although the PROMs results are adjusted for casemix, a small number of providers may face an exceptionally complex casemix that is not fully or appropriately accounted for. These providers will therefore be identified as outliers in the PROMs publications. Commissioners are likely to already be aware of such cases and must agree to pay the full BPT. We anticipate that any such agreement will only be valid until the casemix adjustment in PROMs better reflects the complexity of the provider's casemix.

## 6. Locally determined prices

322. National prices can sometimes be adjusted through local variations or, where they do not adequately reimburse efficient costs because of certain issues, through local modifications. Where there are no national prices, local prices must be agreed between commissioners and providers.

323. This section sets out the principles that apply to all locally determined prices (Section 6.1). It contains the rules for local variations (Sections 6.2) and the method used by NHS Improvement to assess local modifications (Sections 6.3). In addition it contains rules on local prices (Section 6.4). It also has guidance on the application of the principles, rules and method.<sup>95</sup>

324. This section is supported by the following information:

- a. Annex E: guidance on currencies with no national price
- b. Annex A: lists high cost drugs, devices and procedures.
- c. Annex C: technical guidance for mental health clusters.
- d. [New payment approaches for mental health services](#).<sup>96</sup>

325. It is also supported by the following documents available [here](#).<sup>97</sup>

- a. local variations template (relevant to Section 6.2)
- b. local modifications template and worked example (relevant to Section 6.3)
- c. local prices template (relevant to Section 6.4).

### 6.1. Principles applying to all local variations, local modifications and local prices

326. Commissioners and providers must apply the following three principles when agreeing a local payment approach:

- a. the approach must be in the **best interests of patients**
- b. the approach must **promote transparency** to improve accountability and encourage the sharing of best practice
- c. the provider and commissioner(s) must **engage constructively** with each other when trying to agree local payment approaches.

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<sup>95</sup> Commissioners have a duty to have regard to such guidance under the 2012 Act, Section 116(7).

<sup>96</sup> <https://improvement.nhs.uk/resources/new-payment-approaches/>

<sup>97</sup> [www.gov.uk/guidance/nhs-providers-and-commissioners-submit-locally-determined-prices-to-monitor](http://www.gov.uk/guidance/nhs-providers-and-commissioners-submit-locally-determined-prices-to-monitor)

327. These principles are explained in more detail in sections 6.1.1 to 6.1.3 and are additional to other legal obligations on commissioners and providers. These include other rules set out in the national tariff, and the requirements of competition law, procurement law, regulations under Section 75 of the 2012 Act,<sup>98</sup> and NHS Improvement's provider licence.

#### **6.1.1. Best interest of patients**

328. Local variations, modifications and prices must be in the best interest of patients today and in the future. In agreeing a locally determined price, commissioners and providers must therefore consider the following factors:

- a. Quality: how will the agreement maintain or improve the outcomes, patient experience and safety of healthcare today and in the future?
- b. 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?
- c. Innovation: how will the agreement support, where appropriate, the development of new and improved service delivery models which are in the best interest of patients today and in the future?
- d. Allocation of risk: how will the agreement allocate the risks associated with unit costs, patient volumes and quality in a way that protects the best interests of patients today and in the future?

#### **6.1.2. Transparency**

329. Local variations, modifications and prices must 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 best practice examples and innovation in service delivery models or payment approaches can be shared more widely. In agreeing a locally determined price, commissioners and providers must therefore consider the following factors:

- a. Accountability: how will relevant information be shared in a way that allows commissioners and providers to be held to account by one another, patients, the general public and other stakeholders?
- b. Sharing best practice: how will innovations in service delivery or payment approaches be shared in a way that spreads best practice?

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<sup>98</sup> See the National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2013 (SI 2013/500).

### **6.1.3. Constructive engagement**

330. Providers and commissioners must engage constructively with each other to decide on the mix of services, delivery model and payment approach that deliver 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.

331. In agreeing a locally determined price, commissioners and providers must therefore consider the following factors:

- 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 and procurement law (if applicable)?<sup>99</sup>
- Information-sharing: are there agreed policies for sharing relevant and accurate information in a timely and transparent way to facilitate effective and efficient decision making?
- 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?

### **6.1.4. Guidance on applying the principles applying to all local variations, local modifications and local prices**

#### *Record-keeping*

332. Providers and commissioners should maintain a record of how local payment approaches comply with the principles. The content and level of detail of this record will vary depending on the circumstances. For example, more information is likely to be required for high value contracts than for lower value contracts. Further (non-exhaustive) examples are provided in the box below.

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<sup>99</sup> 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.



## Examples of what information a record might contain

Providers and commissioners should consider whether to include the following in their record:

- reasons for choosing to use a local payment approach
- details of any engagement with patients, community groups, carers and other third parties and how their views have been taken into account before agreeing the approach
- reasons for specifying the services in a particular way
- rationale for combining payment for several different services as a bundle and the composition of that bundle, if applicable
- analysis of how the services will be delivered in a way that is co-ordinated from the perspective of patients alongside other healthcare, health-related and social care services
- details of the due diligence applied to the information used to inform the local payment approach
- rationale for key terms of the agreement, for example, prices, quality requirements that the provider must satisfy, how performance will be assessed during the contract, the consequences of breaches, and the duration of the contract.

*How we will assess whether local payment approaches are in the best interests of patients*

333. When assessing compliance with the requirement to apply the principle that local payment approaches must be in the best interests of patients, we will examine whether providers and commissioners have considered all relevant factors. The extent to which, and way in which, the four factors listed in Section 6.1.1 need to be considered will differ according to the characteristics of the services and the circumstances of the agreement.

334. To have considered a relevant factor properly, we would expect providers and commissioners to have:

- a. obtained sufficient information
- b. used appropriately qualified/experienced individuals to assess the information
- c. followed an appropriate process to arrive at a conclusion.

335. It is up to providers and commissioners to determine how to consider the factors set out above based on the matter in hand.

### *Evaluation and sharing of best practice*

336. We encourage commissioners and providers to use the rules for locally determined prices as a basis for considering how they can improve the payment system, especially where care is being delivered in a new way. We are interested in learning from commissioners and providers that are implementing new payment approaches to enhance system-wide incentives: for example, to focus on prevention, integration of care, improved outcomes and improved patient experiences. Such payment approaches might include pathway, capitation or outcomes-based payments.
337. To determine whether local payment approaches have achieved their desired objectives and inform future decision-making, we recommend that commissioners and providers plan to evaluate the success of new payment approaches. We encourage commissioners and providers to share the results of any evaluation processes.

### *Guidance on a framework for constructive engagement*

338. We believe that the principles will be consistent with existing practice for many providers and commissioners. However, we recognise that this will not always be the case, particularly where providers and commissioners do not have existing contractual relationships.
339. Below we set out a framework that could be used as a guide to facilitate constructive engagement where commissioners and providers do not already have a framework. It has been designed with local payment approaches agreed through negotiation rather than competitive procurement in mind. It includes four stages, which are explained in more detail below. In summary, to implement the framework in full, providers and commissioners would have to:
- a. **establish a working group** for contract negotiations in relation to locally determined prices
  - b. **define roles and responsibilities** for members of the working group, including relevant clinicians and other stakeholders, where appropriate
  - c. **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
  - d. **document progress and outputs** for the working group and contract negotiation, including any planned evaluation, if appropriate.

## **Establish a working group**

340. 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:

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

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

## **Define roles and responsibilities**

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

- a. 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 might be appropriate
- b. agreement on the representation required at each meeting of the working group for it to be quorate
- c. 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.

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

## **Agree objectives, timescales and rules**

344. 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. We explain each of these elements below.

345. 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:
- a. clearly define the issues and the services within the scope of the working group
  - b. set specific objectives in relation to each issue or group of services that is in scope
  - c. agree when the objectives must be completed and how they should be measured
  - d. agree a process for updating or changing objectives when appropriate
  - e. agree clear long-term objectives that are consistent with the strategic plans of the parties in the working group.
346. 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 responsible for delivery.
347. We would encourage the working group to agree rules or guidelines that facilitate constructive engagement and effective contract negotiation.
348. The working group is most likely to be effective if it has access to relevant and accurate information 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.
349. 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.
350. In negotiations on 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:
- a. 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

- b. replicate the provisions for dispute resolution in the NHS Standard Contract<sup>100</sup>
- c. agree when and how the working group should use these dispute resolution options.

### **Document progress and outputs**

351. The working group should document its progress and outputs. As well as meeting minutes, we expect it to prepare a constructive engagement report, covering:
- a. the agreed roles and responsibilities of the working group, including a list of its main representatives and the chair or co-chair
  - b. the agreed objectives of the working group and the services covered
  - c. a list of the meetings of the working group
  - d. a clear statement of the outcome of the process, including points of agreement and disagreement.
352. This information could be used as evidence of compliance with the requirements for constructive engagement set out in Section 6 of the 2017/19 NTPS.
353. As well as the constructive engagement report, we encourage working groups to evaluate the payment approaches they agree, to inform future negotiations.

## **6.2. Local variations**

354. Local variations are adjustments to a national price<sup>101</sup> or a currency for a nationally priced service, agreed by one or more commissioners and one or more providers. They only affect services specified in the agreement and the parties to that agreement. A local variation can be agreed for more than one year, although it must not last longer than the relevant contract. Each variation applies to an individual service with a national price (ie an individual HRG). However, commissioners and providers can enter into agreements that cover multiple variations to several related services.

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<sup>100</sup> These provisions allow for support by third party organisations such as the Centre for Effective Dispute Resolution to help resolve disputes.

<sup>101</sup> Local variations are covered by sections 116(2), 116(3) and 118(4) of the 2012 Act.

### 6.2.1. Rules for local variations

355. For a local variation to be compliant with the national tariff, commissioners and providers must comply with the following rules.<sup>102</sup>

#### Rules for local variations

1. The commissioner and provider must apply the principles set out in Section 6.1 when agreeing a local variation.
2. The local variation must be documented in the commissioning contract between the commissioner and provider for the service to which the variation relates.<sup>103</sup>
3. The commissioner must submit a written statement of the local variation to NHS Improvement using the local variation template. NHS Improvement will publish the templates it receives on behalf of the commissioner.
4. The deadline for submitting the statement is 30 June 2017. For local variations agreed after this date, the deadline is 30 days after the agreement.

### 6.2.2. Guidance on when the use of local variations is likely to be appropriate

356. The local variation rules are intended to give commissioners and providers an opportunity to innovate in the design and provision of services for patients. For example, allowing them to:

- a. offer innovative clinical treatments, deliver integrated care pathways or deliver care in new settings
- b. bundle or unbundle existing national currencies to design a new service
- c. design a new integrated service that combines service elements with national and local currencies
- d. support wide-scale reconfiguration and integration of primary, secondary and social care services with payment aligned to patient outcomes
- e. amend nationally specified currencies or prices to reflect significant differences in casemix compared with the national average

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<sup>102</sup> The rules in this section are made under the 2012 Act, Section 116(2).

<sup>103</sup> The NHS Standard Contract is used by commissioners of healthcare services (other than those commissioned under primary care contracts) and is adaptable for use with a broad range of services and delivery models.

- f. share contracting risks and gains between commissioners and providers to incentivise better care for patients
  - g. support changes in the way urgent and emergency care is provided locally.
357. However, it is not appropriate for local variations to be used to introduce price competition that could create undue risks to the safety or the quality of care for patients.

*Guidance on urgent and emergency care (UEC) local variations*

358. To support delivery of local objectives, providers and commissioners delivering sustainability and transformation plans (STP) may wish to move away from nationally specified currencies and/or prices for urgent and emergency care (UEC). Any new payment approach could be a short-term proposal while the local health economy transforms the way it provides UEC, or a longer-term move away from paying for UEC on a wholly activity basis. This guidance sets out how local variations may be developed, tested and adopted locally to support UEC service transformation.<sup>104</sup>
359. While it may be appropriate for local areas to move away from the current payment approach for UEC, the new payment approach should not be a simple block payment without any link to activity levels, quality of care or consideration of the balance of risk between provider and commissioner.
360. New models of UEC delivery are likely to take several years to fully establish. Local variations can support implementation of the care model as it scales up over time by allowing an alternative payment model to be adopted in the short term, during any transition and in the longer term.

*Examples of local variations for UEC services covered by the national tariff*

361. Local areas should decide on the payment model and scope that will best deliver their aims locally, ensuring alignment with STP plans and compliance with the rules in Section 6.2.1 and principles outlined in Section 6.1.
362. Examples of the types of local variation that could be considered include:
- a. payment based on an agreed level of activity and associated spend, overlaid with a gain and loss share
  - b. payment comprising a fixed (core) element and an activity-based element
  - c. whole population budget (WPB), overlaid with a gain and loss share.

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<sup>104</sup> [www.nhs.uk/NHSEngland/keogh-review/Pages/published-reports.aspx](http://www.nhs.uk/NHSEngland/keogh-review/Pages/published-reports.aspx)

363. All local variations should also ideally be linked to achieving system-wide quality and outcomes metrics decided locally and aligned with STP objectives.
364. The choice and scope of any local variation will depend on several factors including:
- a. the stage of service transformation a local area is in
  - b. whether the care model is being delivered by existing provider entities or an integrated care organisation.
365. Areas seeking to explore a system-wide local variation (eg a WPB) for an integrated care organisation or alliance of providers may find existing webinars<sup>105</sup> useful and should continue to monitor the NHS Improvement website for future publications.<sup>106</sup>
366. Support may be available from NHS Improvement and NHS England: we are keen to learn from any new payment approaches being developed. Please contact [pricing@improvement.nhs.uk](mailto:pricing@improvement.nhs.uk).

*Commissioners' responsibility for publishing local variations and submitting information to NHS Improvement*

367. Under the 2012 Act, commissioners must maintain and publish a written statement of any local variation.<sup>107</sup> They should publish each statement by 30 June 2017 or if the variation is agreed after this date, within 30 days of the variation agreement. These statements (which can be combined for multiple services) must include details of previously agreed variations for the same services.<sup>108</sup> Commissioners must therefore update the statement if they agree changes to the variations covered by the statement.
368. The rules on local variations (see Section 6.2.1) require a commissioner to use NHS Improvement's template when preparing the written statement and to submit that statement to NHS Improvement.
369. NHS England requires commissioners to include their written statement of each local variation in Schedule 3 of their NHS Standard Contracts. Commissioners should use the template provided by NHS Improvement to prepare the written statement. (The template and a worked example can be downloaded from NHS

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<sup>105</sup> [Capitation: context and vision; Population, scope and new care models; Gain and loss sharing; Determining the budget](#)

<sup>106</sup> <https://improvement.nhs.uk/resources/?keywords=pricing>

<sup>107</sup> 2012 Act, Section 116(3).

<sup>108</sup> 2012 Act, Section 116(3)(b).



Improvement's [Pricing Portal](#).<sup>109</sup>) The completed template should be included in the commissioning contract (Schedule 3 of the NHS Standard Contract).

370. NHS Improvement will publish these templates on its website so that all agreed local variations are accessible to the public from a single location. Where NHS Improvement 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 (eg making the written statement available on their own website).

### 6.3. Local modifications

#### 6.3.1. What are local modifications?

371. 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.

372. Local modifications can only be used to increase the price for an existing currency or set of currencies. Each local modification applies to a single service with a national price (eg an HRG). In practice several services may be uneconomic as a result of similar cost issues.

373. There are two types of local modification:

- a. Agreements: where a provider and one or more commissioners agree a proposed increase to a nationally determined price for a specific service. For local modification agreements, NHS Improvement requires commissioners and providers to prepare joint submissions.
- b. Applications: where a provider is unable to agree an increase to a nationally determined price with one or more commissioners and instead applies to NHS Improvement to increase that price.

374. Local modifications are subject to approval (in the case of local modification agreements) or grant (in the case of local modification applications) by NHS Improvement.<sup>110</sup> To be approved or granted, NHS Improvement must be satisfied that without the local modification, providing a service at the nationally determined price would be uneconomic.

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<sup>109</sup> <https://ldp.monitor-nhsft.gov.uk/>

<sup>110</sup> 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.

### **6.3.2. Overview of our method for determining local modifications**

375. NHS Improvement's method<sup>111</sup> is intended to identify cases where a local modification is appropriate for a provider with costs of providing a service (or services) that are higher than the nationally determined price(s) for that service (or services). Applications and agreements<sup>112</sup> must be supported by sufficient evidence to enable NHS Improvement to determine whether a local modification is appropriate, based on our method.

376. NHS Improvement's method requires that commissioners and providers:

- a. apply the principles outlined in Section 6.1
- b. demonstrate that services are uneconomic in accordance with Section 6.3.3
- c. comply with our conditions for local modification agreements and applications set out in sections 6.3.4 to 6.3.6.

377. NHS Improvement will determine the circumstances or areas in which the modified price is to be payable (subject to any restrictions on the circumstances or areas in which the modification applies).

378. NHS Improvement may take into account previously agreed local modifications when considering an agreement to extend a local modification, in cases where it can be demonstrated that the underlying issues have not changed.

### **6.3.3. Determining whether services are uneconomic**

379. NHS Improvement's method involves determining whether the provision of the service at the nationally determined price would be uneconomic and applying additional conditions.<sup>113</sup> In relation to determining whether the provision of the service is uneconomic, local modifications agreements and applications must demonstrate that:

- a. The provider's average cost of providing each service is higher than the nationally determined price.
- b. The provider's average costs are higher than the nationally determined prices as a result of issue(s) that are:
  - i. specific: the higher costs should only apply to a particular provider or subset of providers and should not be nationally applicable; for example,

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<sup>111</sup> Under the 2012 Act, Monitor is required to publish in the national tariff its methods for deciding whether to approve local modification agreements or grant local modification applications.

<sup>112</sup> The 2012 Act, Section 124(4), requires that an agreement submitted to Monitor must be supported by such evidence as Monitor may require.

<sup>113</sup> Monitor reserves the right to grant an application, in exceptional circumstances, even if the conditions have not been met.

we would not normally consider an issue to be specific if a large number of providers have costs that are similarly higher than the national price

- ii. identifiable: the provider must be able to identify how the issue(s) it faces affect(s) the cost of the services
- iii. non-controllable: the higher costs should be beyond the direct control of the provider, either currently or in the past. Previous investment decisions that continue to contribute to high costs for particular services may reflect management choices that could have been avoided (for example private finance initiatives). Similarly, antiquated estate may reflect a lack of investment rather than an inherent feature of the local healthcare economy. In both such cases, we will not normally consider the additional costs to be non-controllable. This means that higher costs as a result of previous investment decisions or antiquated estate are unlikely to be grounds for a local modification. Any differences between a provider's costs and a reasonably efficient provider when measured against an appropriately defined group of comparable providers would also be considered to be controllable. NHS Improvement also considers CNST costs to be controllable and therefore unlikely to be the grounds for a local modification
- iv. not reasonably reflected elsewhere: the costs should not be adjusted for elsewhere in the calculation of national prices, rules or variations, or reflected in payments made under the Sustainability and Transformation Fund.<sup>114</sup>

380. Local modifications agreements and applications must also propose a modification to the nationally determined prices of the relevant services which specifies the circumstances or areas in which the proposed modification is to apply, and the expected volume of activity for each relevant commissioner for the relevant period (which must not exceed the period covered by the national tariff).

#### **6.3.4. Additional condition for local modification agreements**

381. 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

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<sup>114</sup> NHS Improvement may take into account any payment received by a provider under the Sustainability and Transformation Fund when determining the amount of the local modification to be approved.

proposed local modification (which must not exceed the period covered by the national tariff).<sup>115</sup>

### **6.3.5. Additional conditions for local modification applications**

382. For local modification applications, five additional conditions must also be satisfied. The applicant provider must:

- a. demonstrate it has a deficit equal to or greater than 4% of revenues at an organisation level in 2016/17 for applications in 2017/18 or 2017/18 for applications in 2018/19; our guidance on how providers should calculate deficits for the purpose of this condition is contained in Section 6.3.16
- b. demonstrate the services are commissioner-requested services (CRS)<sup>116</sup> or, in the case of NHS trusts or other providers that are not licensed, the provider cannot reasonably cease to provide the services
- c. demonstrate it has first engaged constructively with its commissioners<sup>117</sup> 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 NHS Improvement
- d. 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
- e. submit the application to NHS Improvement by 30 September 2017 for applications in 2017/18 or 30 September 2018 for applications in 2018/19, unless there are exceptional circumstances (for example, where there is a clear and immediate risk to patients).

383. NHS Improvement reserves the right to grant an application, in exceptional circumstances, even if the conditions set out above have not been met.

### **6.3.6. Guidance on the application of the method**

384. When assessing local modification agreements and applications we will review the allocation of costs to other services associated with the service(s) for which a local modification is sought (for example, other services in the same service

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<sup>115</sup> 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)).

<sup>116</sup> See: *Guidance for commissioners on ensuring the continuity of health services; Designating commissioner requested services and location specific services*, 28 March 2013.

<sup>117</sup> Constructive engagement is also required by condition P5 of the Provider Licence, in cases where a provider believes that a local modification is required.

line). If it appears that costs have not been properly allocated, for example where there are unexpected variations in the profitability of services, we will take that into account in deciding whether the provider has higher costs in relation to the services for which a local modification is sought.

### 6.3.7. Local modification template

385. NHS England and NHS Improvement have developed a local modifications [template](#)<sup>118</sup> for commissioners and providers (providers only in the case of a local modification application)<sup>119</sup> to use when recording and submitting a proposed local modification to NHS Improvement. The completed template should be submitted with the supporting evidence described in Section 6.3.3, and a self-certification letter confirming the accuracy of that information, including any extra terms of the proposed local modification that are not included in the template.
386. The local modifications template and a worked example can be downloaded from [www.monitor.gov.uk/locallydeterminedprices](http://www.monitor.gov.uk/locallydeterminedprices). It includes detailed instructions on how to fill in each field. Answers should be clear, concise and submitted with evidence where required.
387. The template contains the information that NHS Improvement will publish for all approved local modifications and therefore should not include any information identifying individual patients. It also should not include information which is confidential to third parties, unless consent has been obtained.

### 6.3.8. Dates

#### *Applications*

388. If an application for a local modification is successful, NHS Improvement will determine the date from which the modification will take effect. In most cases, applications will be effective from the start of the following financial year, subject to any changes in national prices, to allow commissioning budget allocations to take account of decisions.
389. In exceptional cases (particularly where delay would cause unacceptable risk of harm to patients), NHS Improvement will consider making the modification effective from an earlier date.

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<sup>118</sup> [www.gov.uk/guidance/nhs-providers-and-commissioners-submit-locally-determined-prices-to-monitor](http://www.gov.uk/guidance/nhs-providers-and-commissioners-submit-locally-determined-prices-to-monitor)

<sup>119</sup> 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 the information. In the case of an application, relevant commissioners will be given the opportunity to provide their own submissions.

## *Agreements*

390. The terms of a local modification agreement should be included in the relevant commissioning contract (using the NHS Standard Contract where appropriate)<sup>120</sup> once they are agreed between the provider and commissioner. If the terms of a local modification agreement are included in the commissioning contract before NHS Improvement approves the local modification, the contract may provide for payment of the modified price pending a decision by NHS Improvement. But if NHS Improvement subsequently decides not to approve the modification, the modification would not have effect and the national price applies. The provider and commissioner must then agree a variation to the commissioning contract to stop the modification, and may agree a mechanism for adjustment and reconciliation in relation to the period before the refusal, or possibly a local variation to the national price.

391. 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)).

### **6.3.9. Publication of local modifications**

392. As required by the 2012 Act (sections 124(7) and 125(7)), NHS Improvement is required to publish information on all local modification agreements and applications that are approved or granted.

393. NHS Improvement will also publish key information on local modification agreements and applications that are rejected, unless the circumstances of the case make it inappropriate.

### **6.3.10. Notifications of significant risk**

394. Under the 2012 Act, if NHS Improvement 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, it is required to notify NHS England and any CCGs it considers appropriate. These bodies must then have regard to the notice from NHS Improvement when deciding on the commissioning of NHS healthcare as required by the 2012 Act, sections 126(1) to 126(3).

### **6.3.11. Guidance on preparing evidence for a local modification**

395. The supporting information required for a local modification will depend in part on the specific circumstances faced by the provider. This section provides

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<sup>120</sup> Providers and commissioners should refer to the latest available guidance on the NHS Standard Contract. See guidance on the variations process for the NHS Standard Contract for 2013/14.

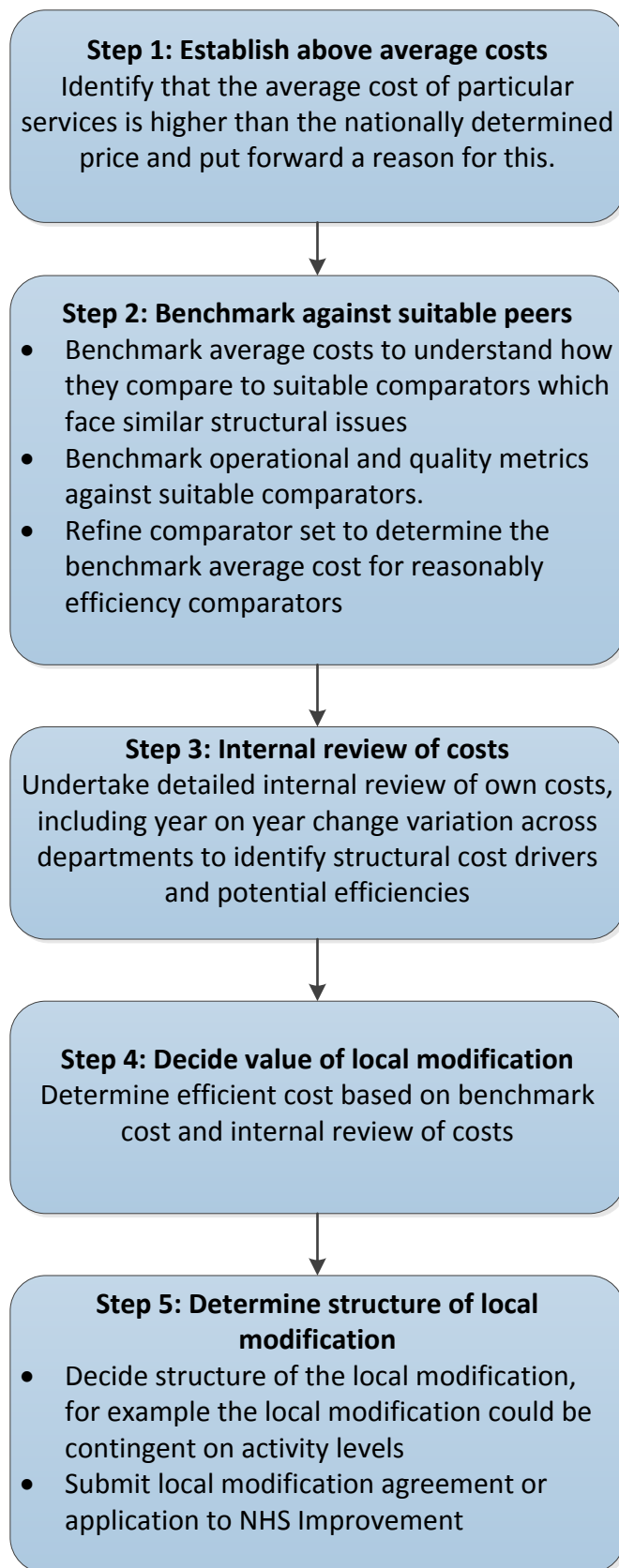
guidance on the type of evidence that we would expect providers and commissioners to submit to demonstrate that (i) the relevant services are uneconomic, and (ii) the proposed local modification reflects a reasonably efficient cost of provision, given the cost issues faced by the provider. We set out the process for local modifications below.

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

- a. demonstrate that its average costs are higher than the nationally determined price for the services covered by the local modification
- b. benchmark its average costs, operating efficiency and outcome measures against suitable comparators, refining the comparator group as necessary
- c. present a detailed analysis of its costs, which demonstrates that it faces higher costs as a result of issues meeting the criteria set out in Section 6.3.4, and identify potential efficiencies
- d. 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.

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

**Figure 4: Process for preparing evidence for a local modification**



398. We explain each of these steps in further detail below.



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

399. We would expect a provider to establish that its average costs are higher than the nationally determined price for a service or group of services as part of its ongoing analysis of operations. Providers should then explain why costs are higher, with reference to our criteria for demonstrating services are uneconomic at the national price.
400. 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 NHS Improvement's [Approved costing guidance](#).<sup>121</sup>
401. When submitting a local modification to NHS Improvement for approval, commissioners and providers should provide a detailed explanation of the issues they face in their local health economy and the drivers of higher costs.
402. For example, higher costs could be related to:
- a. 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 expensive equipment, 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.<sup>122</sup>
  - b. 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.
403. A hypothetical example is presented below to illustrate how a rural provider that faces scale issues might assess whether it meets our criteria for local modifications.

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<sup>121</sup> [www.gov.uk/government/publications/approved-costing-guidance](http://www.gov.uk/government/publications/approved-costing-guidance)

<sup>122</sup> Commissioners may consider the relationship between scale and clinical quality. For example, some services may require a certain volume to be provided in a clinically safe and sustainable way.

### Example 1: Criteria for demonstrating services are uneconomic at the national price

Consider an isolated, rural provider with a low catchment population that could face higher average costs due to geographic location and insufficient scale. Here is how they could apply the criteria for identifying cost differences.

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

- the need to pay for 24-hour staff cover for a relatively low number of patients
- 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 extra costs outlined above. Step 4 in this section presents guidance on the evidence we would expect providers and commissioners to submit to show how a particular issue affects their reported costs.

**Non-controllable:** In this hypothetical example, the provider may not be able to control its costs for the following reasons:

- A healthcare 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. 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 to ensure clinical safety.

**Not reasonably reflected elsewhere:** Nationally determined prices may not fully reflect the cost differences faced by the provider. Although 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 demonstrating services are uneconomic at the national price. 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 in the local health economy it serves.

## *Step 2: Benchmarking average costs, operational metrics and outcome measures*

404. Providers should benchmark themselves against a suitable comparator group to demonstrate they are reasonably efficient, given the cost issues they face. This process should include comparisons of average costs, operating metrics and outcome measures. The provider will probably 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 cost issues faced by the provider. It may also help to identify opportunities for improvements in efficiency.
405. There are a range of publicly available data sources that commissioners and providers may use to benchmark performance.
406. The section below sets out the following processes:
- a. selecting a suitable comparator group
  - b. comparing average costs
  - c. comparing operational and quality metrics
  - d. refining the comparator group.

### **6.3.12. Selecting a suitable comparator group**

407. 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 NHS Improvement. They should consider the drivers of higher costs when identifying an appropriate comparator group. For example, if a provider believes that service provision is uneconomic due to insufficient case volume, we would expect its comparator group to include providers with similarly low case volumes.<sup>123</sup> CCG groupings (compiled by NHS Digital) could be used as one way of selecting suitable comparators.
408. It is important to consider both the number and relevance of providers included in the comparator group and balance both factors. Reducing the size of the group may focus on the most comparable providers but could also mean that analysis is sensitive to the cost reporting or specific circumstances of particular providers.
409. The following factors may be relevant when deciding on an appropriate comparator group:

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<sup>123</sup> 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.

- a. region type (Office for National Statistics super group)
- b. demographics (for example, based on age profile)
- c. deprivation (for example, based on Economic Deprivation Index)
- d. size of trust or service (by revenue or activity)
- e. service type (ie A&E with/without trauma, nurse-led, consultant-led, etc).

### 6.3.13. Comparing average costs

410. Providers should benchmark their average costs for the services covered by a local modification at both specialty and HRG level, where it is possible to do so.<sup>124</sup> This analysis should demonstrate:

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

411. Despite data quality issues, 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. We encourage the use of PLICS data where possible and practical.

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

413. Table 14 presents 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 14: Example of average cost benchmarking**

Provider	FCEs <sup>125</sup> (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

414. 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. Table 14 shows that all the providers face above-average costs for the

<sup>124</sup> We would generally expect this benchmarking to be carried out at the HRG root level.

<sup>125</sup> Finished consultant episodes.

selected HRG. It 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.

415. If an issue affects multiple HRGs in a particular department, it may be informative to group HRGs together and look at the weighted average cost for the department. Table 15 illustrates how this information could be presented.

**Table 15: 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					

### 6.3.14. Comparing operational and quality metrics

416. As well as comparing their average costs to the comparator group, providers should 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.
417. Providers should compare operational metrics at organisational and department levels, where data are 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. Table 16 illustrates benchmarking operational metrics.

**Table 16: 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			

418. 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 several 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.

419. 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).

420. We would expect a provider to explain:

- a. how it compares to the comparator group
- b. the reasons for any differences identified.

421. Providers should also submit a detailed explanation of potential opportunities to improve operational efficiency and clinical outcomes.<sup>126</sup> 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

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<sup>126</sup> We would expect this to include an explanation of trends in operational and quality metrics over time, where data are available.

‘avoidable’ costs should not be included in the value of the proposed local modification.

### 6.3.15. Refining the comparator group

422. 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. We would expect providers to start with a relatively large comparator group and exclude providers at each stage, ie following analysis of costs, operating efficiency and quality. Reasons for including or excluding particular providers in the comparator group should be clearly explained.
423. 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 that face the same issues. Providers should then benchmark their costs against this refined comparator group.

#### *Step 3: Detailed review of provider’s own costs*

424. Providers are expected to review their own costs in detail to demonstrate that services are uneconomic at the national price. Providers should explain their costs in relation to the costs of the comparator group and the nationally determined price. We expect providers to explain cases where they have deviated from the principles in NHS Improvement’s [Approved costing guidance](#).<sup>127</sup>
425. Providers should identify how and at what level the 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 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 issues have an impact and then consider whether there is any reason that specific HRGs would not be affected by the issues faced.<sup>128</sup>

426. In all cases, providers should submit:

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<sup>127</sup> These principles are: stakeholder agreement; consistency; data accuracy; materiality; causality and objectivity; and transparency. See NHS Improvement’s *Approved costing guidance* for further information.

<sup>128</sup> Local modifications apply at the individual service level (ie at the HRG level). However, to the extent that the same issue affects a group of services, we encourage providers to analyse costs at this level.

- a. a breakdown of cost drivers, by cost pool (for example, direct, indirect and overhead costs)
  - b. an explanation of internal variation in costs, for example across wards, clinicians, year-on-year and seasonal fluctuations
  - c. an explanation and quantification of the additional costs arising from issues meeting the criteria for demonstrating that services are uneconomic at the national price; this could for example include staff costs, where additional staff are required, or depreciation costs where fixed assets are not fully utilised
  - d. an explanation of why the provider's costs differ from the nationally determined price and the costs of the comparator group
  - e. an explanation and quantification of opportunities for improved efficiency.
427. 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 NICE and Royal College guidelines).
428. An example of a rural provider that faces scale issues is presented below.

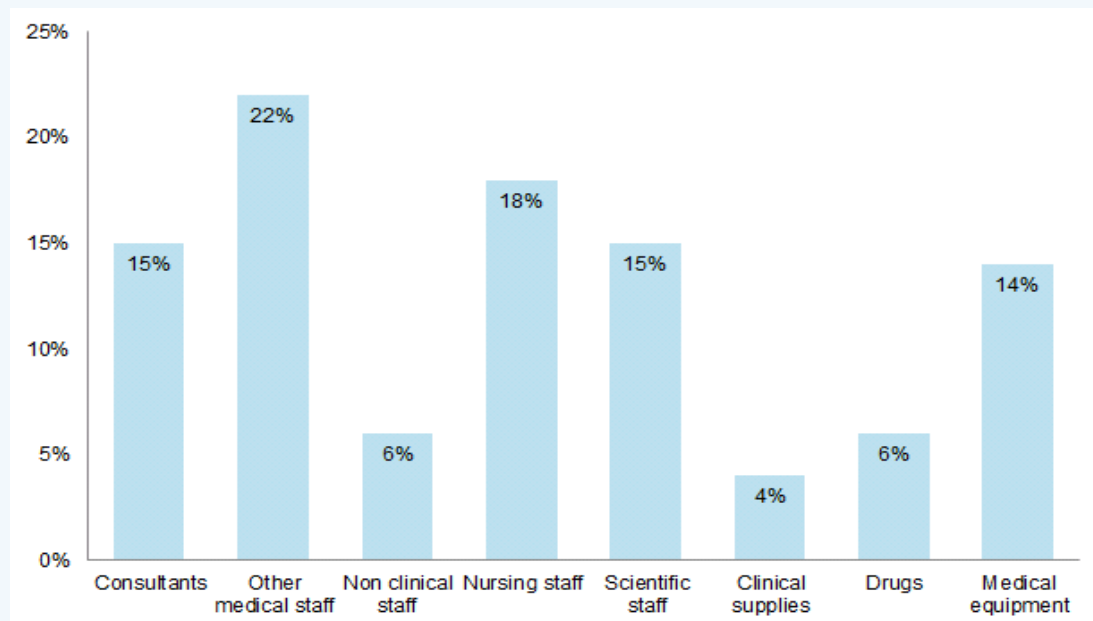


## Example 2: Analysing cost drivers

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 break down those costs into specific cost drivers.

### An 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. 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.

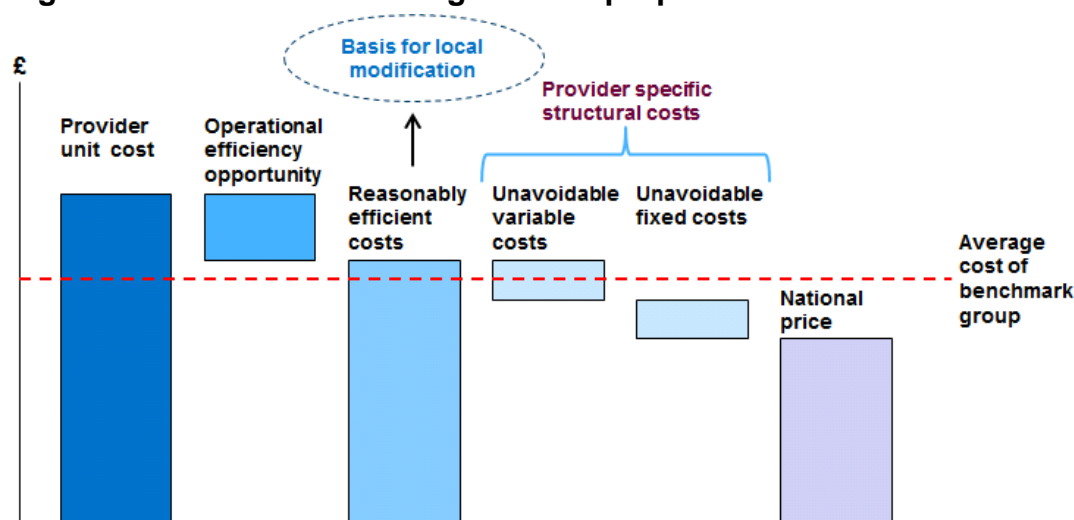
Providers could also break down total costs into fixed costs, semi-fixed costs and variable costs to explain how particular issues affect their cost base. For example, the high fixed costs associated with certain services could affect the viability of providing these services for a provider with low 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.

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

429. 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 NHS Improvement, 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 some of the extra cost incurred by the provider arises from inefficiency rather than the cost issues identified. The efficient cost should be based on expected activity levels, given the issues faced by a provider.
430. 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 cost issues faced by the provider in question. Figure 5 summarises the components of an illustrative provider's costs and the basis on which the value of a local modification should be calculated.

**Figure 5: Basis for calculating value of proposed local modification**



431. As shown above, in determining the value of the local modification, providers should take account of the potential to improve operational efficiency. Providers facing higher costs may still reasonably be expected to take steps to improve efficiency, while 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.

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

*Step 5: Determine structure of the local modification*

433. 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.
434. 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.
435. As noted above, 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 the fixed costs associated with providing certain services.
436. Consider again the example 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 (ie after national variations) for this HRG is £1,000 per unit, which means the provider would normally be paid £4 million for providing the service. After applying NHS Improvement'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 million for 4,000 units of activity, and its shortfall on fixed costs is estimated to be £1 million in total.
437. 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.

### 6.3.16. Guidance on the provider deficit condition for local modification applications

438. 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 the previous financial year (ie 2016/17 for an application in 2017/18; 2017/18 for an application in 2018/19). This requirement does not apply to local modification agreements.

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

440. 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 that are not related to the ongoing delivery of services.

### 6.3.17. Technical definition of deficit

441. Table 17 shows the formula to use to calculate the ‘adjusted’ provider deficit that NHS Improvement will consider when assessing local modification applications.

**Table 17: 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		

442. 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.

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

#### *NHS foundation trusts*

444. 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.

445. If audited data are 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.

#### *NHS trusts*

446. We expect NHS trusts to calculate their deficit using Financial Information System (FIMS) data.

447. If audited data are 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.

448. Providers should express their deficits as a percentage of total revenue.

### **6.4. Local prices**

449. 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 agree 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.<sup>129</sup> We have set both general rules and rules specific to particular services. There are two types of general rule:

- a. Rules that apply in all cases when a local price is set for services without a national price. See Section 6.4.1.
- b. Rules that apply only to local price-setting for services with a national currency (but no national price). See Section 6.4.2.

450. As well as the general rules, there are rules specific to particular services. See Sections 6.4.3 to 6.4.7.

451. Table 18 shows which rules apply to which area of activity.

**Table 18: Application of pricing rules**

Rule	Acute	Mental health	Community	Ambulance
1	✓	✓	✓	✓
2	✓	✓	✓	✓
3	✓	✓	✓	✓
4	✓	✓	✓	✓
5	✓	✗	✗	✗
6	✗	✓	✗	✗

<sup>129</sup> 2012 Act, Section 116(4)(b) and (12) and Section 118(5)(b).

Rule	Acute	Mental health	Community	Ambulance
7	x	✓	x	x
8	x	✓	x	x
9	x	✓	x	x
10	x	x	x	✓

#### 6.4.1. General rules for all services without a national price

452. Rules 1 and 2 apply when providers and commissioners agree local prices for services without national prices. The rules apply irrespective of whether or not there is a national currency specified for the service.

#### Local pricing rules: general rules for all services without a national price

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

**Rule 2:** Commissioners and providers should have regard to the efficiency and cost uplift factors for 2017/18 and 2018/19 (as set out in sections 4.7 and 4.8 of this document) when setting local prices for services without a national price for 2017/18 and 2018/19, respectively.<sup>130</sup>

#### 6.4.2. General rules for services with a national currency but no national price

453. Services that have national currencies but no national price are:

- a. working age and older people **mental health services**
- b. **ambulance services**
- c. the following **acute services**
  - i. specialist rehabilitation (25 currencies based on patient complexity and provider/service type)
  - ii. critical care – adult and neonatal (13 HRG-based currencies)
  - iii. HIV adult outpatient services (three currencies based on patient type)
  - iv. renal transplantation (nine HRG-based currencies)
  - v. dialysis for acute kidney injury

<sup>130</sup> For 2017/18, the efficiency factor is 2% and the cost uplift factor is 2.1%. This gives a net increase of 0.1%. For 2018/19 the efficiency factor and cost uplift factors are 2% and 2.1% respectively. This results in a net increase of 0.1%.

vi. positron emission tomography and computed tomography (PET/CT)

454. The following rules apply when providers and commissioners are setting local prices for these services.

### **Local pricing rules: general rules for services with a national currency but no national price**

#### **Rule 3:**

**(a)** Where a national currency is specified for a service, it must be used as the basis for local price-setting for the service covered by that national currency, 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 NHS Improvement using the standard templates provided by NHS Improvement.

**(c)** The completed templates must be submitted to NHS Improvement by 30 June 2017. For local prices agreed after this date, the deadline is 30 days after the agreement.

**(d)** The national currencies specified for the purposes of this rule and Rule 4 are the currencies specified in Annex E.

#### **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 it, the commissioner and provider may agree a price without using the national currency.

When doing so, providers and commissioners must adhere to the requirements (b), (c), (d) and (e) below, which are intended to mirror the requirements for agreeing a local variation for a service with a national price, set out in Section 6.2.

**(b)** The agreement must be documented in the NHS Standard 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 NHS Improvement, within 30 days of the relevant contract being signed or in the case of an agreement during the term of an existing contract, the date of the agreement.

**(d)** The commissioner must have regard to the guidance in Section 6.2 when preparing and updating the written statement.

**(e)** The commissioner must submit the written statement to NHS Improvement.

455. The templates referred to in Rule 3 can be found [here](#).<sup>131</sup>

### 6.4.3. High-cost drugs, devices and listed procedures

456. A number of high-cost drugs, devices and listed procedures are not reimbursed through national prices. Instead, they are subject to local pricing in accordance with the rule below. Annex A sets out the updated list of excluded drugs, devices and procedures for the 2017/19 NTPS that are subject to local prices.

#### Local pricing rules: rules for high-cost drugs, devices and listed procedures

##### Rule 5:

**(a)** As high-cost drugs, devices and listed procedures are not national currencies, Rules 3 and 4 in Section 6.4.2, including the requirement to disclose unit prices to NHS Improvement, do not apply.

**(b)** Local prices for high-cost drugs, devices or listed procedures must be paid as well as the relevant national price for the currency covering the core activity. However, the price for the drug, device or procedure must be adjusted to reflect any part of the cost already captured by the national price.

**(c)** The price agreed should reflect the actual cost to the provider, or the nominated supply cost, or any national reference price, whichever is lower.

**(d)** As the price agreed should reflect either the actual cost, or the nominated supply cost, or any national reference price, the requirement to have regard to efficiency and cost uplift factors detailed in Rule 2 does not apply.

**(e)** The 'nominated supply cost' is the cost which would be payable by the provider if the device or drug was supplied in accordance with a requirement to use a supplier or intermediary, or via a framework, specified by the commissioner, pursuant to a notice issued under SC 36.50 of the NHS Standard Contract (nominated supply arrangements). The national reference prices are nationally set by NHS England and are based on the current best procured price achieved for a product or group of products by the NHS.

### 6.4.4. Guidance on local price rules

457. 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 reported by their providers.

<sup>131</sup> [www.gov.uk/guidance/nhs-providers-and-commissioners-submit-locally-determined-prices-to-monitor](http://www.gov.uk/guidance/nhs-providers-and-commissioners-submit-locally-determined-prices-to-monitor)



Providers and commissioners should also bear in mind the requirements as set out in the NHS Standard Contract, such as in relation to counting and coding. NHS England includes an adjustment in commissioner allocations to reflect the unavoidable pressures of rurality and sparsity. When adjusting prices agreed in previous years, commissioners and providers may agree to make price adjustments that differ from the adjustments for national prices where there are good reasons to do so.

458. Rule 2 requires commissioners and providers to have regard to national price adjustments. In effect they should be used as a benchmark to inform local negotiations. However, these are not the only factors that should be considered.

459. Relevant factors may include, but are not restricted to:

- a. commissioners agreeing to fund service development improvements
- b. additional costs incurred as part of any agreed service transformation
- c. taking account of historic efficiencies achieved (eg where there has been a comprehensive service redesign)
- d. comparative information (eg benchmarking) about provider costs and opportunities for local efficiency gains
- e. differences in costs incurred by different types of provider, for example differences in indemnity arrangements (such as contributions to the CNST); or other provider specific costs (such as the effects of changes to pensions and changes to the minimum wage).

*Guidance on applying local price rules to acute prescribed services not subject to a national price*

460. 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 that are currently paid for on a pass-through basis
- d. adhere to maximum reference prices when determining high cost drug and device spending, and

- e. take into account activity plans that support agreed service redesigns, which may include some services being decommissioned or changes to clinical thresholds

## 6.5. Mental health services

461. This section sets out the local pricing rules for mental health services for working age adults and older people and for IAPT services. In addition to rules 1 to 4, providers and commissioners must adhere to the requirements of rules 6 to 9.

### Local pricing rules: rules for mental health services

#### Rule 6: Using the mental healthcare clusters

All providers of services covered by the care cluster currencies (see Annex B3) must record and submit the cluster data to NHS Digital as part of the Mental Health Services Dataset, whether or not they have used the care clusters as the basis of payment. This should be completed in line with the mental health clustering tool (Annex B3) and mental health clustering booklet to assign a care cluster classification to patients.

#### Rule 7: Local prices for mental health services for working age adults and older people

- a. Providers and commissioners must link prices for mental health services for working age adults and older people to locally agreed quality and outcome measures and the delivery of access and wait standards.
- b. Providers and commissioners must adopt one of the following payment approaches in relation to mental health services for working age adults and older people:
  - i. episode of care<sup>132</sup> based on care cluster currencies
  - ii. capitation,<sup>133</sup> having regard to the care cluster currencies and any other relevant information, in accordance with the requirements of Rule 4(b) to (e)
  - iii. an alternative payment approach agreed in accordance with the requirements of Rule 4 (b) to (e).

<sup>132</sup> An episodic payment approach is the payment of an agreed price for all the healthcare provided to a patient during an agreed time period – the episode. The price paid will depend on the cluster to which the patient has been assigned. Further detail on this is set out in supplementary guidance.

<sup>133</sup> Capitated payment is where a provider or a group of providers are paid to cover a range of care for an identified population, made on a per person basis and adjusted to reflect the different needs of people with mental ill health.

## Rule 8

### Local prices for Improving Access to Psychological Therapies (IAPT)

- a. Providers and commissioners must adopt an outcomes-based payment model for IAPT services from 1 April 2018/19. The model must reflect the 10 national outcome measures collected in the IAPT dataset.
- b. All providers of IAPT services are required to submit IAPT dataset to NHS Digital, whether or not the person receiving services is covered by a care cluster.

## Rule 9

Providers and commissioners must ensure that any agreed payment approach enables appropriate patient choice.

### *Guidance on the application of Rule 7*

462. Guidance on capitation, episode of care payment models and linking outcomes to payment for mental health can be found [here](#).<sup>134</sup> In all cases (including where an alternative payment approach is agreed under Rule 7(b)iii) these care models must be based on outcomes.

### *Guidance on the application of Rule 8*

463. Regardless of the payment approach agreed locally, prices must be linked to outcomes

464. An outcomes-based payment model under Rule 8(a) should include two components:

- a. basic service price: includes an amount for assessment and an amount for the package of care provided taking into account of the severity and complexity of a service user
- b. outcomes payment: the contract allows for use of a suite of metrics that are collected locally and submitted to NHS Digital. This includes 10 national outcomes measures (5 access targets and 5 outcome measures):
  - i. Access:

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<sup>134</sup> [improvement.nhs.uk/resources/new-payment-approaches/](https://improvement.nhs.uk/resources/new-payment-approaches/)

- 1.a.i.1. waiting times
- 1.a.i.2. black or minority ethnic
- 1.a.i.3. over 65
- 1.a.i.4. specific anxieties
- 1.a.i.5. self referral
- ii. Percentage achieving good clinical outcomes
- iii. Percentage with reduced disability and improved wellbeing
- iv. Percentage with good employment outcomes
- v. Patient experience
  - 1.a.v.1. satisfaction
  - 1.a.v.2. choice of therapy

465. We recognise that the above outcomes are not exhaustive and it is expected that there will be other outcomes that may be agreed that reflect local needs and priorities.

466. It is known that complexity of patient need as identified from the Mental Health Clustering Tool affects the cost of treatment. Prices should reflect service user severity and complexity.

467. All IAPT providers should submit monthly data to NHS Digital in accordance with the NHS Standard Contract.

468. We expect providers and commissioners to shadow test their preferred payment approach in 2017/18. To further support shadow testing and implementation NHS Digital is developing a tool to support payment for IAPT services.

469. We will provide further guidance to support the implementation of outcomes-based payment approaches for IAPT services.

## **6.6. Ambulances services**

470. This section sets out the rules for local price setting for ambulance services with and without national currencies.

471. In addition to rules 1 to 4, providers and commissioners must adhere to the requirements of Rule 10.

## Local pricing rules: rule for ambulance services

### Rule 10

Quality and outcome indicators must be agreed locally and included in the commissioning contracts covering the services in question.

## 6.7. Primary care services

472. Primary care is a core component of NHS care provision. It enables local populations to access advice, diagnosis and treatment. Primary care services cover a range of activities, including:

- a. providing co-ordinated care and support for general health problems
- b. helping people maintain good health
- c. referring patients on to more specialist services where necessary.

473. Primary care is also a key part of the provision of community-based health services, interacting with a number of other community-based health teams, such as community nurses, community mental health teams and local authority services.

*Primary care payments determined by, or in accordance with, the NHS Act 2006 framework*

474. The rules on local price-setting (as set out in Section 6.4) do not apply to the payments for primary care services which are determined by, or in accordance with, regulations or directions, and related instruments, made under the primary care provisions of the National Health Act 2006 (chapters 4 to 7). This includes, for example, core services provided by general practices under General Medical Services (GMS) contracts. For 2017/18 to 19/20, the national tariff will not apply to payments for these services.

*Primary care payments that are not determined by, or in accordance with, the NHS Act 2006 framework*

475. The national tariff covers all NHS services provided in a primary care setting where the price payable for those services is not determined by or in accordance with the regulations, directions and related instruments made under the NHS Act 2006. Therefore, where the price for services is determined by agreement between NHS England, or a CCG, and the primary care provider, the rules for local payment must be applied. This includes:

- a. services previously known as 'locally enhanced services' and now commissioned by CCGs through the NHS Standard Contract (eg where a

GP practice is commissioned to look after patients living in a nursing or residential care home)

- b. other services commissioned by a CCG in a primary or community care setting using its power to commission services for its local population (eg walk-in or out-of-hours centre services for non-registered patients).<sup>135</sup>

476. The price paid to providers of NHS services in a primary care setting in most of these instances will be locally agreed, and providers and commissioners of these services must therefore adhere to the general rules set out in Section 6.4.1.

## **6.8. Community services**

477. Community health services cover a range of services that are provided at or close to a patient's home. These include community nursing, physiotherapy, community dentistry, podiatry, children's wheelchair services and primary care mental health services. The services provided by community providers are a vital component in the provision of care to elderly patients and those with long-term conditions.

478. Community providers often work closely with other NHS and social care providers, such as GPs and local authority services, and are a key contributor to developing more integrated health and social care and new care models.

479. Payment for community health services must adhere to the general rules set out in Section 6.4.1. This allows continued discretion at a local level to determine payment approaches that deliver quality care for patients on a sustainable basis.

480. Where providers and commissioners adopt alternative care pathway payment approaches that result in the bundling of services covered, at least in part, by national prices, the rules for local variations must be followed (see Section 6.2).

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<sup>132</sup> These are arrangements made under the NHS Act 2006, Section 3 or 3A.

## 7. Payment rules

481. The 2012 Act allows for the setting of rules relating to payments to providers where health services have been provided for the purposes of NHS (in England).<sup>136</sup>

### 7.1. Billing and payment

482. Billing and payment must be accurate and prompt, in line with the terms and conditions set out in the NHS Standard Contract. Payments to providers may be reduced or withheld in accordance with provisions for contractual sanctions set out in the NHS Standard Contract (eg sanctions for breach of the 18-week referral to treatment standard).

### 7.2. Activity reporting

483. For NHS activity where there is no national price, providers must adhere to any reporting requirements set out in the NHS Standard Contract.

484. For services with national prices, providers must submit data as required under SUS guidance.<sup>137</sup>

485. The dates for reporting activity and making the reports available will be published on the NHS Digital website.<sup>138</sup> NHS Digital will automatically notify subscribers to its e-bulletin when these dates are announced.

486. NHS England has approval from the Secretary of State to allow CCGs and commissioning support units (CSUs) to process a limited set of personal confidential data when it is absolutely necessary to do so, for invoice validation purposes. This approval is subject to a set of conditions. NHS England has published advice online<sup>139</sup> about these conditions and sets the actions that CCGs, CSUs and providers must take to ensure they act lawfully.

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<sup>136</sup> 2012 Act, Section 116(4)(c)

<sup>137</sup> <http://content.digital.nhs.uk/susguidance>

<sup>138</sup> [www.hscic.gov.uk/sus/pbrguidance](http://www.hscic.gov.uk/sus/pbrguidance)

<sup>139</sup> See: *Who pays? Information governance advice for invoice validation* at [www.england.nhs.uk/wp-content/uploads/2013/12/who-pays-advice.pdf](http://www.england.nhs.uk/wp-content/uploads/2013/12/who-pays-advice.pdf)

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