NHS

2019/20 National Tariff Payment System – Annex DtG

Guidance on locally determined prices

A joint publication by
NHS England and NHS Improvement

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1 Introduction

1. 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, commissioners and providers must determine local prices in accordance with any rules specified in the national tariff.

2. Section 6 of the 2019/20 National Tariff Payment System (NTPS) sets out the principles that apply to all locally determined prices (Section 6.1). It contains the rules for local variations (Section 6.2) and the method used by NHS Improvement to assess local modifications (Sections 6.3) and rules on local prices (Section 6.4).

3. This document provides additional guidance on the application of the locally determined pricing principles, the local modifications method and the local pricing rules.

2 Principles applying to all local variations, local modifications and local prices

4. Section 6.1 of the 2019/20 NTPS states that commissioners and providers must apply the following three principles when agreeing a local payment approach:

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

5. 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.

6. 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:

- Quality: how will the agreement maintain or improve the clinical effectiveness, patient experience and safety of healthcare today and in the future?
- Cost-effectiveness: how will the agreement make healthcare more cost effective, without reducing quality, to enable more effective use of resources for patients today and in the future?
- Innovation: how will the agreement support, where appropriate, the development of new and improved service delivery models which are in the best interests of patients today and in the future?
- Allocation of risk: how will the agreement allocate the risks associated with unit costs, patient volumes and quality in a way that protects the best interests of patients today and in the future?

7. The extent to which, and way in which, these factors need to be considered will differ according to the characteristics of the services and the circumstances of the agreement.

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

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

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

3 Local modifications

10. Section 6.3 of the 2019/20 NTPS sets out the method used by NHS Improvement for deciding whether to approve a local modification agreement and for determining local modification applications.

11. There are two types of local modification:

- 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.
- 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.

12. This section provides guidance on the application of the method for local modifications and other related matters.

3.1 Guidance on the application of the method

13. 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 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.

3.2 Local modification template

14. NHS England and NHS Improvement have developed a local modifications template[1] for commissioners and providers (providers only in the case of a local modification application)[2] 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 of the 2019/20 NTPS. It should also be accompanied by a self-certification letter

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[1] www.gov.uk/guidance/nhs-providers-and-commissioners-submit-locally-determined-prices-to-monitor

[2] 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.

confirming the accuracy of that information, including any extra terms of the proposed local modification that are not included in the template.

15. The template includes detailed instructions on how to fill in each field. Answers should be clear, concise and submitted with evidence where required.

16. 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 that is confidential to third parties, unless consent has been obtained.

3.3 Publication of local modifications

17. 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.

18. 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.

3.4 Notifications of significant risk

19. 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).

3.5 Guidance on preparing evidence for a local modification

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

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

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

22. This process can be broken down further into five steps:

    1 Establish above-average costs
    2 Benchmark against suitable peers
    3 Internal review of costs
    4 Decide value of local modification
    5 Determine structure of local modification

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

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

24. 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.

25. 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.[3]

[3] https://improvement.nhs.uk/resources/approved-costing-guidance/

26. 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.

27. For example, higher costs could be related to:

- **Scale:** certain services may require a minimum volume of procedures to be provided efficiently, as a result of the fixed or semi-fixed costs of providing them. For example, clinical best practice may require the use of specific 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.[4]
- **Casemix:** certain groups of patients have greater health needs than others and are therefore costlier to treat. For example, older patients and people from economically deprived areas may have, on average, more complex health needs. Providers in an area with a large proportion of older 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.

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

28. 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.

29. There are a range of publicly available data sources that commissioners and providers may use to benchmark performance.

30. The section below describes the following processes:

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4 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.

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

Selecting a suitable comparator group

31. 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.[5] CCG groupings (compiled by NHS Digital) could be used as one way of selecting suitable comparators.

32. 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.

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

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

Comparing average costs

34. 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.[6] This analysis should demonstrate:

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[5] The provider could use 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.

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

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

35. 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.

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

Comparing operational and quality metrics

37. 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.

38. 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.

39. 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.

40. 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).

41. We would expect a provider to explain:

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

42. Providers should also submit a detailed explanation of potential opportunities to improve operational efficiency and clinical outcomes.[7] This will be important when determining the value of the local modification, as there may be steps that the provider could reasonably be expected to take to reduce costs; these 'avoidable' costs should not be included in the value of the proposed local modification.

Refining the comparator group

43. 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.

44. 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

45. 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

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

deviated from the principles in NHS Improvement's Approved costing guidance.[8]

46. 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.[9]

47. In all cases, providers should submit:

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

48. 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).

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

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8 These principles are: stakeholder agreement; consistency; data accuracy; materiality; causality and objectivity; and transparency. See https://improvement.nhs.uk/resources/approved-costing-guidance/ for further information.

9 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.

49. 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.

50. 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.

51. 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.

52. 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

53. 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.

54. 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.

55. 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.

3.6 Guidance on the provider deficit condition for local modification applications

56. 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 organisational level in the previous financial year (ie 2018/19 for an application in 2019/20). This requirement does not apply to local modification agreements.

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

58. 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.

3.7 Technical definition of deficit

59. Table 1 shows the formula to use to calculate the 'adjusted' provider deficit that NHS Improvement will consider when assessing local modification applications.

Table 1: Components of 'adjusted deficit' calculation

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

60. 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.

61. 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

62. 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.

63. 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

64. We expect NHS trusts to calculate their deficit using financial information system (FIMS) data.

65. 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.

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

4 Local pricing rules

67. Commissioners and providers must work together to agree prices for services without national prices. Section 6.4 of the 2019/20 NTPS specifies a series of rules that must be followed when doing this. Section 7 sets out separate rules for emergency care services.

68. This section provides additional guidance for applying these rules.

4.1 General local pricing rules – rules 1 to 4

69. 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. Providers and commissioners should also bear in mind the requirements 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.

70. 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.

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

- commissioners agreeing to fund service development improvements
- additional costs incurred as part of any agreed service transformation
- taking account of historic efficiencies achieved (eg where there has been a comprehensive service redesign)
- comparative information (eg benchmarking) about provider costs and opportunities for local efficiency gains
- 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

72. In negotiating prices for an acute prescribed specialised service not subject to a national price, NHS England and the provider should:

- make steps towards convergence to efficient benchmark values (subject to significant differences in service specifications)
- 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
- review any existing arrangements for gain sharing for high cost drugs and devices that are currently paid for on a pass-through basis
- adhere to maximum reference prices when determining high cost drug and device spending
- take account of activity plans that support agreed service redesigns, which may include some services being decommissioned or changes to clinical thresholds.

4.2 Rules for mental health services – rules 6 to 9

Guidance on the application of Rule 7

73. Please see the supporting document *Guidance on blended payment for mental health* for more details about the application of Rule 7.

Guidance on the application of Rule 8

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

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

- **Basic service price:** includes an amount for assessment and an amount for the package of care provided taking account of the severity and complexity of a service user
- **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:
  - five access targets:

  - waiting times
  - access for black, Asian and minority ethnic patients
  - access for over 65s
  - access for people with specific anxieties
  - access for self-referred patients
- five outcome measures
  - percentage achieving good clinical outcomes
  - percentage with reduced disability and improved wellbeing
  - percentage with good employment outcomes
  - patient satisfaction
  - patient choice of therapy.

76. We recognise that the above outcomes are not exhaustive and other outcomes may be agreed that reflect local needs and priorities.

77. Complexity of patient need, as identified from the mental health clustering tool,[10] affects the cost of treatment. Prices should reflect service user severity and complexity.

All IAPT providers should submit monthly data to NHS Digital in accordance

[10] The mental health clustering tool is available in Annex DtE

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