2014/15 National Tariff Payment System: A Consultation Notice

Annex 1B: Stakeholder engagement

3 October 2013

Publications Gateway Reference 00471 **IRCP 05/13**

1 Annex 1B: Stakeholder engagement

The key objective of the stakeholder engagement process was to provide an opportunity for stakeholders to contribute to the development of our proposals for the *2014/15 National Tariff Payment System* in a timely way and ahead of the publication of this statutory consultation notice. This provided stakeholders with an early opportunity to comment on the policy proposals, mitigating the risk of delay to the final publication of the *2014/15 National Tariff Payment System*.

This annex describes the activities undertaken jointly by NHS England and Monitor for the stakeholder engagement process, and how the key feedback from those activities has helped us develop our policies, for 2014/15 and beyond. This annex is structured as follows:

- firstly, we describe the key activities in the stakeholder engagement process, and summarise the extent to which the process achieved the 'success measures' agreed between NHS England and Monitor in advance of the process;
- secondly, we summarise the quantitative survey responses to the Tariff Engagement Document (TED) and subsequent webinars;
- thirdly, we set out the key themes emerging from the stakeholder engagement process, and provide our comments on that feedback; and
- finally, we list the stakeholders we invited to participate in the stakeholder engagement process.

1.1 Activities undertaken to engage with stakeholders

Three key activities and a range of other supporting activities were undertaken jointly between NHS England and Monitor to engage with stakeholders on our proposals. These were as follows:

- publication of the *National Tariff 2014/15: An Engagement Document*, *Local payment variations document* and the *Draft guidance on the Enforcement of the National Tariff;*;
- regional workshops to engage on key proposed policies; and
- webinars on local variations, local modifications and our proposed method for determining national prices.

These are described in more detail below as well as a range of other supporting activities.

1.1.1 Publications

National Tariff 2014/15: An Engagement Document

This document (referred to also as the *Tariff Engagement Document* or "TED") was published on 13 June 2013, setting out our preliminary proposals for the 2014/15 national tariff. Monitor sent to all of the stakeholders (as identified in subsection 1.4 below) an email, with a link to the document itself and an associated podcast on both Monitor and NHS England's web sites. Stakeholders were asked to comment on 33 questions in the document and 178 responses were received.

Local Payment Variations document

This document was published alongside the TED on 13 June 2013. Monitor sent, to all of the stakeholders listed in Subsection 1.4 below, an email with a link to the document. Each document asked for comments on four questions. There were 76 responses to this document.

Draft guidance on Enforcement of the National Tariff

This document was published alongside the TED on 13 June 2013. Monitor sent, to all of the stakeholders listed in Subsection 1.4 below, an email with a link to the document. Each document asked for comments on four questions. There were 55 responses to this document.

1.1.2 Regional workshops

Four all-day workshops were held in London, Leeds, Leicester and Newbury during July 2013. These were primarily aimed at providers and commissioners, but attracted participants from a range of backgrounds. Staff from both Monitor and NHS England facilitated discussions, primarily focusing on the issues and policy proposals discussed in the TED. These workshops were attended in total by 199 delegates.

Attendees at each engagement workshop were asked to complete a short evaluation form after each event, and 25% (50 responses) of the workshop attendees did so.

The purpose of the questionnaire was to assess to what extent the workshops improved stakeholder understanding of proposed policies and that they felt they had an opportunity to contribute and felt listened to. Prior to carrying out these workshops, NHS England and Monitor had agreed some 'success measures' metrics in respect of this.

The questions asked and responses to the evaluation are set out in the tables below.

Table 1B-1: Success Criteria

Success Criteria	Target %	Result %
Stakeholders engaged in the workshops had an opportunity to have their say and feel listened to.	66	96 (providers) 100 (commissioners)
Stakeholders engaged in the work shops understand the proposed NTD	55 (providers) 55 (commissioners)	78 (providers) 81 (commissioners)

Source: Monitor and NHS England engagement feedback forms

Table 1B-2: detailed provider feedback on the understanding of the proposed NTD pre and post the engagement workshops

	Before the workshop %		After the workshop %	
	Very high/fairly high	Very low/fairly low	Very high/fairly high	Very low/fairly low
Proposed changes to the national tariff for 2014/15?	62	38	85	15
Proposed methodology for the 2014/15 national tariff	65	35	81	19
Proposed changes to the rules and variations?	54	46	73	27
Longer term vision for the payment system	50	50	72	28

Source: Monitor and NHS England engagement feedback forms

Table 1B-3: detailed commissioner feedback on the understanding of the proposed NTD pre and post engagement workshops

	Before the workshop %		After the workshop %	
	Very high/fairly high	Very low/fairly low	Very high/fairly high	Very low/fairly low
Proposed changes to the national tariff for 2014/15?	52	48	93	7
Proposed methodology for the 2014/15 national tariff	63	47	93	7
Proposed changes to the rules and variations?	37	63	82	18
Longer term vision for the payment system	26	74	58	42

Source: Monitor and NHS England engagement feedback forms

In summary, based on the feedback provided, both success measures for the sector engagement process have been met. However, it is also clear that more work is required to develop provider and commissioner understanding on the proposed changes to rules and variations and on the long-term vision for the payment system.

1.1.3 Webinars

Five webinars[1] were held in July, subsequent to the workshops. These were primarily aimed at providers and commissioners as an additional opportunity to engage on some of the topics covered in the workshops.

1.1.4 Other supporting activities

During the engagement period we also met or spoke with a number of organisations to discuss our proposals in more detail as well as to listen to their ideas for the future of the payment system. These organisations included:

> NHS Confederation, NHS Partners Network, Foundation Trust Network, National Association of Primary Care, Healthwatch England, Richmond Group (of charities), Association of the British Pharmaceutical Industry, Association of British Healthcare Industries, National Health Service Trust Development Authority, British Medical Association, Royal College of Emergency Physicians and the Association of UK University Hospitals.

In addition, we gave presentations on our plans to the Social Partnership Forum, the Foundation Trust Network Finance and Commercial Leads Network, and held a round table discussion with NHS commissioners at the Commissioning Show held in London in June.

[1] Three on local variations (with 162 participants), one on pricing methodology (with 258 participants) and one on local modifications (with 80 participants).

1.2 Summary of quantitative survey responses from the TED and webinars

In this section, we summarise the quantitative survey responses from the TED and webinars. By asking stakeholders to respond via an online form, we were able to quantitatively assess the feedback.

1.2.1 Summary of quantitative survey responses to the TED

In the TED, stakeholders were invited to respond (via a web-based survey) to 11 'general' questions and 22 'detailed' questions. Of these, 14 quantitative questions required responses in the form of a scale comprising:

- "strongly agree";
- "agree";
- "disagree"; and
- "strongly disagree.

The table below sets out the responses to these questions, split between providers and CCGs/CSUs[2].

The number of responses to each question varied between c. 50 and c.150. The relatively small sample size means it is difficult to make statistical inferences about the level of support shown across all stakeholders, and the results should be interpreted accordingly.

[2] In one case, one CSU responded on behalf of 9 CCGs. This has been treated as one for the purposes of the analysis.

Table 1B-4: Summary of quantitative findings from published documents

	Providers %		CCGs/CSUs%	
	(Strongly) agree	**(Strongly) disagree**	**(Strongly) agree**	**(Strongly) disagree**
Q1. To set national prices for 2014/15, we propose to apply 2013/14 prices but adjust these generally to reflect changes in input costs and provider efficiency. We refer to this as a "rollover" approach since we are rolling over the previous years' prices. Do you agree with this rollover approach for the 2014/15 national tariff (using 2013/14 prices as the basis for adjustment)?	73	27	86	14
Q2. We are proposing to calculate the cost uplift to the 2013/14 national tariff prices by using various sources of data for pay settlements, drugs, and other cost inflation appropriately weighted by their proportion of total costs. This matches the approach taken in previous years for uplifting costs for expected inflation. a) Do you agree with our proposed method for calculating cost uplifts? b) Do you agree with our proposed data inputs for calculating cost uplifts?	88 (a) 80 (b)	12 (a) 20 (b)	100 (a) 100 (b)	0 (a) 0 (b)
Q3.The purpose of the efficiency requirement is to reflect the efficiency gains that an average provider should reasonably be expected to make. Given the data available to us, we have estimated the efficiency opportunity for the sector as a whole and then considered what proportion of this should be reflected in unit prices. Do you agree with our proposed method for calculating efficiency?	41	59	84	16
Q4. Do you agree with the methods that we propose to use to calculate 2014/15 prices?	72	28	92	8
Q5. Over the coming years, we intend to review all aspects of the rules set out under the Payments by Results payment system. For 2014/15 we intend to leave certain variations and rules unchanged, while making modifications to others. To what extent do you agree with our general approach to rules and variations?	80	20	78	22

	Providers %		CCGs/CSUs%	
	(Strongly) agree	(Strongly) disagree	(Strongly) agree	(Strongly) disagree
Q7. Monitor has set out a proposed methodology for determining whether services are uneconomic and therefore eligible for a local modification. For a service to be uneconomic, the provider must face unavoidable, structural differences in costs which are not reflected in the national tariff price or mandatory variations. We set out a number of criteria which we will use to determine what constitutes an unavoidable, structural cost difference. To what extent do you agree with these proposed criteria?	72	28	53	47
Q8. Given the potential cross-subsidisation between different national tariff services, Monitor is proposing to limit local modification applications to cases where the provider cannot cease to provide the service and where the provider is in deficit on national tariff services and at an organisational level. (These limitations do not apply to agreements). To what extent do you agree with our outlined method for limiting local modification applications?	45	55	78	22
Q11. We will conduct an impact assessment of the new national tariffs each year. In this we are seeking to identify, describe, and quantify the impacts or consequences of the changes in national tariffs on the main stakeholder groups, namely: commissioners, providers and ultimately, patients. In so far as possible, we will conduct our assessment using evidence provided by stakeholders. Where we do not have evidence or the evidence is incomplete or of questionable quality, we shall conduct qualitative (descriptive) assessment of impacts. To what extent to you agree with our proposed approach to impact assessment?	91	9	94	6
DQ2. Do you agree with the methods we propose to adopt for determining the new or changed prices as a result of currency design changes?	89	11	87	11
DQ4. In 2013/14 maternity pathway payments were introduced replacing previous HRG-based currencies. We propose keeping these provisions for 2014/15 but to signal our intention to mandate national prices from 2015/16.Do you agree with this proposed time frame to move to mandated national prices?	54	46	69	31

	Providers %		CCGs/CSUs%	
	(Strongly) agree	**(Strongly) disagree**	**(Strongly) agree**	**(Strongly) disagree**
DQ5. We propose that the financial risk sharing provision that exists in 2013/14 for providers and commissioners to share the overall impact of unbundling diagnostic imaging is removed for 2014/15. To mitigate the financial risk of an increase in activity as a result of unbundling we are proposing to maintain the marginal rate of 50% above the activity baseline adjusted for expected trend growth in 2014/15.Do you agree with the proposed change in financial risk sharing provisions?	56	44	67	33
DQ6. Which of the following options do you support for external beam radiotherapy & chemotherapy delivery? a) Complete the transition to national prices (%) b) Maintain the 2013/14 position (%) c) Make further progress towards national prices (%)	*Support:* 46 (a) 36 (b) 18 (c)		*Do not support:* 40 (a) 20 (b) 40 (c)	
DQ8. Use of the mental health care clusters was mandated for use from April 2012. In 2013/14, providers and commissioners were asked to make progress in implementing the care clusters in a number of ways. In 2014/15, we also want to continue to make progress in the implementation of the care clusters and to support the introduction of choice of provider in mental health services. Do you agree with our overall proposed approach for working age and older people's mental health services in 2014/15?	77	23	80	20
DQ15. Are there any circumstances in which local modifications agreements and applications are likely to: a) Have an impact on the incentives on providers of particular NHS services to compete? b) Reduce the quality of care provided by particular providers or in a local healthcare economy overall c) Cause any other unintended detrimental consequences?	81 (a) 67 (b) 73 (c)	19 (a) 33 (b) 27 (c)	80 (a) 80 (b) 82 (c)	20 (a) 20 (b) 18 (c)

1.2.2 Summary of quantitative survey responses to the webinars

Attendees at each webinar (local variations, local modifications, and methodology for determining national prices) were invited to respond to a set of questions relevant to the topic.

The number of responses to each question varied between c. 20 and c.110. The relatively small sample size means it is difficult to make statistical inferences about the level of support shown across all stakeholders, and the results should be interpreted accordingly.

The table below set out the responses to these questions.

Table1B-5: stakeholder feedback from webinars

Local variations				
Q1. Do you agree our objectives for local variation are broadly the right objectives?	Yes (93%)	No (7%)		
Q2. Which of these issues is most important?	Application of variations (41 %)	Willingness (22%)	Contract duration (15%)	Section 75 regulations (12%)
Q3. Which option for designing local variation rules do you prefer?	Review (16%)	Nudge (60%)	Clarify (20%)	Ban (12%)
Q4. How much oversight do you think Monitor and NHS England should have over local variations?	Little (34%)	Moderate (51%)	High (15%)	
Methodology				
Q1. Do you agree with this rollover approach for the 2014/15 national tariff (using 2013/14 prices as the basis for adjustment, as opposed to calculating them from reference costs)?	Yes (81%)	No (19%)		
Q2. Do you agree with our proposed method for calculating cost uplifts	Yes (91%)	No (9%)		
Q3. Do you agree with our proposed method for calculating efficiency?	Yes (44%)	No (56%)		
Q4 To what extent do you agree that this is the right approach to take with regards to conducting an impact assessment	Strongly agree (5%)	Tend to agree (73%)	Tend to disagree (17%)	Strongly disagree (6%)

Local modifications				
Q1. Do you agree with our criteria for identifying structural differences in cost?	Strongly agree (77%)	Tend to agree (22%)	Tend to disagree (1%)	Strongly disagree (0%)
Q2.How long do you think it would take your organisation to work through the data analysis required for a local modification agreement? (%)	Less than a month (0%)	1-3 months (29%)	More than 3 months (35%)	Not sure (35%)
Q3. Do you agree with our proposed deficit criteria for 2014/15?	Yes I agree (31%)	Yes but the deficit should be measured by site (6%)	Yes but the deficit should be measured by service line or department (25%)	No, applications should be open to all provides on all services (38%)
Q4. Which policy are you most likely to use to agree variations to national prices during annual contract negotiations (%)	Local variations (24%)	Local modifications (6%)	A combination of both policies (71%)	Neither policy is likely to be helpful (0%)

1.3 Key themes from sector feedback on TED

As set out in the subsection above, many of our policy proposals received wide support. However, we have identified the key critiques of our proposals from across all of the stakeholder engagement activities.

The tables below set out, for each of our policy proposals, the key themes in the feedback and our response to these themes. The key themes are:

- structure of the national tariff;
- national currencies;
- method for determining national prices;
- national variations;
- local variations;
- local modifications;
- impact assessment; and
- enforcement;

Naturally, we have not been able to itemise every individual comment we have received, but our intention is to reflect the main points that have been raised.

Structure of the national tariff

Topic: Structure of the national tariff		
Theme	**Feedback**	**Our response**
1. Views on whether to have one or multiple documents for the national tariff	Respondents had differing views on the number of and structure of documents: • There was some support for having a single integrated document as opposed to the suite of documents proposed in TED. • Greater clarity and definition was requested (e.g. for "recording", this will remove disputes and challenges from the system) and better delineations between statutory and non-statutory guidance (or mandatory vs. non-mandatory). • An executive summary that is cleaner and easier will help. • Some support for FAQs. • A comprehensive glossary will be required.	***2014/15*** • The 2012 Act sets out its legal requirements for the contents and structure of the national tariff. • Whilst we recognise the existing national tariff guidance is familiar to users of the payment system, the 2012 Act mandates a change to the way information is presented. In particular, the new regulatory structure means that certain elements of the proposed national tariff (for example, currency specifications and method for determining prices) must be published under a section 118 notice. • We have aimed to enhance clarity, cognisant that new users of the payment system will need to understand the *2014/15 National Tariff Payment System* structure. However, we have striven to maintain a balance between familiarity and clarity. We will publish FAQs on policy content and consultation process, and also publish a glossary. ***Long term*** • We will consider the use of a web-based system for publishing the national tariff in future years. In particular, we recognise there may be supporting documentation, relevant to the national tariff, which may need to be updated from time to time, outside of the national tariff cycle.
2. Accessibility and interactivity of the *2014/15 National Tariff Payment System*	• Greater use of interactivity for suite of documentation – e.g. hyperlinks etc.	
3. Structure and clarity of *2014/15 National Tariff Payment System* document compared to DH PbR system 2013/14 guidance	Respondents had different views on how closely we should keep to the format of the previous 2013/14 PbR guidance: • Spread sheets should be more intuitive and use friendly. • Some providers are keen to retain layout and structure of previous PbR system guidance given familiarity with historical approach.	

National currencies

Topic: national currencies		
Theme	**Feedback**	**Our response**
1. PET/CT Scans	• Feedback from the TED and PbR advisory groups (providers and commissioners) is that the 2013/14 price for PET/CT scans is too low. Stakeholders submitted some analysis of costs from a sample of providers. • Feedback suggests that several providers have already negotiated local prices that are higher than the national ones.	***2014/15*** • In light of feedback received we are no longer proposing a national price for PET CT scans.
2. Hip and knee replacement Best Practice Tariffs	• TED feedback was supportive of the approach of paying for outcomes. There were some requests for more detail on how the PROMS score would be calculated, e.g. whether there would be an adjustment for casemix, which year's performance data would be used etc. There was also a suggestion that the criteria should be more challenging.	***2014/15*** • Implement the BPT as set out in the TED, with local variations for those providers who do not achieve the PROMs outcome if they can show they are making or, have agreed, improvements with their commissioner.
3. Major trauma BPT	• No feedback from TED.	***2014/15*** • Given there was no feedback we propose to implement the amended BPT criteria as set out in the TED.
4. Paediatric diabetes	• No feedback from TED.	***2014/15*** • Given there was no feedback we propose to implement the BPT as set out in the TED to increase the scope of the BPT to include non-elective admissions.

Method for determining national prices

Topic: method for determining national prices		
Theme	**Feedback**	**Our response**
1. Level of the efficiency requirement is too high	We received a lot of feedback in this area. 59% of provider responses disagreed with our proposal for the efficiency requirement. Key messages were: • Providers are under too much financial pressure to absorb an efficiency requirement of 3.0% to 4.5%. • There is already considerable pressure on the quality of service due to general budget constraints and increasing demand (particularly in some areas e.g. mental health). • Providers have already delivered substantial efficiency gains – pushing further will have a detrimental impact on provider finances (if quality is to be upheld).	***2014/15*** • In our impact assessment (impact assessment), we assessed a range of financial metrics under two key scenarios: one in which each provider achieves the annual efficiency requirement of 4%, and one in which each provider achieves efficiency gains of just 3%, thereby missing the target by 1%. We have also examined an upside scenario where each provider achieves annual efficiency gains of 4.5%. • On balance, and with particular consideration to providers' cash positions, our analysis suggested that, whilst missing the efficiency target by 1% results in a number of providers moving from a small surplus to a small deficit, the majority of providers remain financially viable. This analysis provides additional reassurance that our proposed efficiency adjustment of 4.0% is reasonable for 2014/15.
1a. The share of total sector efficiencies from providers (i.e. 75-90% in the TED) is too high	• The share of efficiency gains should be split more evenly between commissioners and providers. • Quotes from a speech by Sir David Nicholson are not strong evidence.	***2014/15*** • We have updated our approach to the efficiency requirement, and this split between providers and commissioners no longer forms a key part of our method. Please see Section 5 of the consultation notice for more details.

Topic: method for determining national prices		
Theme	**Feedback**	**Our response**
1b. Some of the evidence cited in the TED is out of date and/or not robust.	• Several reports (McKinsey 2009, Nuffield Trust, and King's Fund 2010) are too out of date to use as evidence for 2014/15. • Sector efficiency estimates of 5 -6 %, based on 4% provider CIP (Cost Improvement Programmes) and 1 -2% commissioner QIPP (Quality, Innovation, Productivity and Prevention) programmes include double counting. • Efficiency gains cited in the TED do not appear to directly relate to acute providers' unit costs. • Some items in the Monitor 2013 evidence base are too optimistic (e.g. "supply chain/procurement") whereas others were not ambitious enough (e.g. "estates optimisation").	***Long term*** • The Monitor 2013 evidence is, we consider, the best forward-looking evidence on efficiency opportunities available. We will build further on the evidence base over time. ***2014/15*** • For setting the efficiency requirement, the oldest reports we cited in the TED are now not considered as so relevant as more recent evidence. • We also agree that there is potential for double counting between CIP and QIPP data and a result have placed less weight on this data point.
1c. Efficiency in the context of pay pressures	• 3.0-4.5% is too high, given pay pressures. • Providers are concerned there is little they can do to efficiency when workforce contracts (and thus are significant proportion of costs) are fixed.	***2014/15*** • We address changes in pay costs via the pay uplift, so the efficiency requirement can be considered separately. We rely on data from the DH in respect of pay inflation.
1d. Sustainability of efficiency gains	• The 'front-loading' of multi-year efficiency targets is not appropriate - "big changes don't all come at once". • Efficiencies of 3%-4.5% for acute providers are not achievable without incentivising the whole system (providers and commissioners) to make changes.	***2014/15*** • For 2014/15, we are satisfied that 4.0% is achievable for providers, based on our evidence (which includes data from FTs on recent and forecast efficiency gains), and supported by our impact assessment. ***Long term*** • In general, we agree that system-wide efficiency is a broader concept than the efficiency opportunities that are relevant to the national tariff.

Topic: method for determining national prices		
Theme	**Feedback**	**Our response**
1e. The efficiency requirement should take more account of individual provider circumstances	• The efficiency requirement does not recognise the circumstances of different providers (for example, providers operating at different levels of efficiency, differences between types of treatments, different models, and different capacity requirements). • There should be greater consideration of the differences across the healthcare sector (e.g. community or mental health) • Trust data is often very poor and is not always a good indication of whether a trust is efficient or inefficient. • Independent sector stakeholders believed Monitor's evidence base did not consider the opportunities and limitations of further efficiency savings to be achieved in the Independent Sector.	***2014/15*** • In principle, there may be reasons why we might expect different efficiency gains from different types of providers. We do not currently have data available that would allow us to propose different efficiency factors for 2014/15, for example, based on different service models and capacity requirements. • There are mechanisms within our proposals to address some differences between providers to some extent (for example, the Market Forces Factor, specialist top up payments, and local modifications). ***Long term*** • As we build up our evidence base, we may, in future, set different efficiency requirements across different service, if we consider it beneficial to patients. In particular, we hope to make use of new and improved cost data (e.g. PLICS) for future national tariffs.
1f. The efficiency requirement will have a negative impact on investment	• The pricing system does not incentivise radical change, such as integration of services, telemedicine, keeping people out of acute care. • Would suggest 2-3 year national tariff to encourage investment and better planning. • The efficiency requirement does not reflect an allowance for providers to invest properly in newer techniques and treatments that could increase the quality and efficiency of care (payback periods are rarely in-year). As a result, providers investing in quality may face transitional short-term spikes, dis-incentivising such initiatives.	***2014/15*** • Based on our impact assessment, we are confident that the proposed efficiency requirement in 2014/15 would not constrain provider investment. • Our proposed rules on local variations are designed to encourage innovative delivery models, and in particular, service integration. ***Long term*** • We are very keen for the payment system to encourage investment that will lead to better patient outcomes in the longer term, and we recognise this in our pricing principles.

Topic: method for determining national prices		
Theme	**Feedback**	**Our response**
1g. The national tariff should better reflect NHS system-wide affordability	• If the efficiency built into prices is less than for the whole of the sector, then it needs to be made clear where the residual amount is to be found. • It is not yet clear how stable the commissioning sector finances are. As such, there is a risk that a higher national tariff efficiency requirement in 2014/15 will also coincide with commissioner budgetary pressures that could lead to individual provider organisations being placed under inappropriate financial pressure. • Giving an efficiency target to providers and not commissioners was done because it is easier to do than allocated to commissioners.	***2014/15*** • We examined the potential for budget constraints in our impact assessment, and the results of that analysis has reassured us that our proposals strike a reasonable balance between provider viability and the ability of commissioners to purchase more services: given that nominal prices will marginally decrease while nominal funding will slightly increase, we expect that commissioners will have some room to accommodate increased demand in their local health economies. ***Long term*** • NHS England is currently examining how commissioners can be appropriately incentivised.
2. Broad support for the rollover approach, but concerns from some stakeholders	• A pragmatic, sensible approach which reduces volatility in prices for 2014/15 • Gives stability when there is significant change in other parts of the healthcare sector • Consistent prices year on year (and set earlier in the year) is important for planning. It will allow local discussions to focus on transformational service changes, leading to more cost efficient and higher quality patient care.	***2014/15*** • In response to the broadly supportive feedback on the 'rollover' approach for 2014/15, we have maintained this approach.

Topic: method for determining national prices		
Theme	**Feedback**	**Our response**
2a. Implicitly, the national tariff will be based on cost data that is four years old	• Current 3 year lag between the collection of cost data and setting prices is bad; 4 years is worse. • Disappointing that better costing was not going to flow through to the national tariff. • 'Sense checking' current prices against the most up-to-date, accurate and robust costing data would support further modifications. A rollover does not allow for these changes. • Was reporting 2011/12 reference costs a waste of time?	***2014/15*** • We agree that improved costing data is a priority, but we do not have enough data or analysis to make changes for 2014/15. The decision to use a rollover in 2014/15 does not delay the implementation of changes to the use of cost data in the national tariff. • We accept that the costs of some services could have shifted significantly in the last four years, in which case prices will not match costs as closely. However, we consider the positive effects of a rollover national tariff to be more important in 2014/15 (and stakeholders broadly agreed). • For the avoidance of doubt, 11/12 Reference Costs will be very useful data both now and in the future.
2b. A rollover in 2014/15 will lead to a disruptive 'step change' in prices in 2015/16	• The rollover method introduces risk of having a much bigger step change in level/structure of prices when the 2015/16 national tariff is set. • A significant structural change to pricing in 2015/16, coupled with an update to cost data, might destabilise the national tariff. It will be hard for commissioners and providers to make accurate forecasts of future prices.	***Long term*** • We understand this risk and will take steps to manage it. • Our impact assessment will help us to recognise potentially disruptive changes. If we find evidence of changes that could be too disruptive (i.e. potentially detrimental for patients), we will consider transition arrangements.
3. Scope of and value of the cost uplifts	• Feedback on our approach to cost uplifts for 2014/15 was mainly positive. However, we also received feedback that will be useful for us in setting future national tariffs.	***2014/15*** • Given our emphasis on stability, we have followed the DH's approach to cost uplifts as closely as possible.

Topic: method for determining national prices		
Theme	**Feedback**	**Our response**
3a. The cost uplifts should take more account of individual provider circumstances	• The cost uplift factor does not match some provider-specific services (e.g. perinatal pathology) and costs of specific drugs which had a higher inflation rate, particular in the provision of cancer services. • The uplifts should take more account of differences across the sector (e.g. community and mental health are different to acute care).	***Long term*** • We are cautious about making the approach to uplifts more complex at least without careful consideration of options and in consultation with the sector.. This is an example of general challenge in pricing, where we want the benefits of more sophisticated prices, but not make the system overly complex.
3b. The national tariff should use actual, rather than projected, inflation measures.	• Cost uplifts should reflect actual cost changes and not those forecast at the outset of the period.	***2014/15*** • For 2014/15, we wish to keep the method that DH has used previously, which is to use projections of cost changes during the national tariff year. ***Long term*** • It is possible to use actual inflation data. Many pricing regulators apply actual inflation to prices with a lag (e.g. they might use 2012 inflation to set 2013/14 prices, 2013 inflation to set 2014/15 prices, and so on). We will consider various approaches as part of our long-term strategy. • There are pros and cons to alternative approaches, and we do not have a preferred long term approach for cost uplifts yet.
3c. Agency costs are pushing labour costs higher than the general rate of pay costs.	• Agency and temporary staff costs are rising at a significantly higher rate than permanent recruitment in some locales (e.g. London).	***2014/15*** • We are liaising with the DH to ensure that the latest evidence on agency costs will be taken into account either as part of pay inflation or service development cost uplift factors. ***Long term*** • We will look for relevant data for 2015/16 and beyond. We are interested in collecting more data from providers, in case the current cost uplift approach is understating labour costs.

Topic: method for determining national prices		
Theme	**Feedback**	**Our response**
3d. External service development pressures must be reflected in the cost uplifts.	• The uplift factor does not reflect the cost pressures inherent in following advice from relevant bodies (e.g. RCN, NICE) and requirements for OOH care and other regulations, Francis report, etc.	***2014/15*** • Our proposed final prices would include service development costs. We will not have an estimate of these costs until the NHS Mandate is published. Please see Section 5 of the consultation notice for more details.
3e. Other concerns	• The OBR forecast of inflation has consistently been short of the level actually seen, and an allowance should be made for this. • With the rising costs of fuel, several providers believed that this element of cost should be calculated separately, based on the Energy Cost Index. • Some providers raised the issue of adequate IT provision being in the national tariff.	***2014/15*** • For 2014/15, we propose to continue the DH's method of using the forecast of the GDP deflator estimated by the OBR. We are satisfied this is a reasonable proxy for general operating costs (i.e. non-pay, non-drugs) faced by providers. ***Long term*** • We are open to changing our approach to cost uplifts, particularly where we can make better use of independent, more accurate data, and where the case for change is supported by clear evidence.
4. Transparency	• We need clear guidance on how the efficiency requirement is calculated and how it interacts with the cost uplift factors. • There should be more clarity on the inflation to be applied to non-national tariff prices.	***2014/15*** • Subsection 5.4 of the consultation notice explains our process for determining the efficiency requirement. Subsection 5.5 describes the interaction of the efficiency requirement with cost uplifts to calculate prices for 2014/15. • We have included a note in Subsection 5.5 about the price adjustments that should apply to non-national tariff services. ***Long term*** • Our proposals for future national tariffs will continue to be presented widely, and in detail, as part of stakeholder engagement processes. The data and processes that we use to set the efficiency requirement could change significantly.

Topic: method for determining national prices		
Theme	**Feedback**	**Our response**
5. Capital costs treatment is not appropriate	• Capital funding should be part of national tariff setting • Depreciation contained in the national tariff is unlikely to be sufficient for short and long run capital replacement needs because many assets are already fully depreciated, or otherwise not accounted for in costs data. • Land and building costs having recently risen above the longer-term trend line. This is likely to lead to increased estate valuations in the future, which will in-turn increase depreciation costs in a way not reflected in the proposed method. • Some providers have estates that are not fit for purpose but are deterred from investing in more modern premises because they are currently over-paid by national prices. • PFI in cost of capital not adequately covered. • PFI payments are a constraint on cost reduction. • The national tariff should reflect individual provider PFI payments - there are significant differences between providers in relation to PFI	***2014/15*** • Capital costs are already a part of the national tariff (albeit implicitly for 2014/15), because reference costs include items such as depreciation and PFI payments. • This is a very complex area of costing, and we are reluctant to make adjustments to the treatment of capital costs without a comprehensive review. Reform of capital costs, including data and analysis of providers' assets, is likely to be a long-term project. • Given our rollover approach, this issue is mainly relevant to the capital costs component of the cost uplift for the national tariff. • We recognise the risk of forecast error in this area of cost uplifts, but the DH data is the best source that we have available. ***Long term*** • We are likely to continue with sector-wide cost estimates, rather than focusing on individual providers.

Topic: method for determining national prices		
Theme	**Feedback**	**Our response**
6. Prices will not reflect costs closely enough	• Some hospitals are doing more complex procedures than others, and the national tariff does not recognise this. • Stakeholders from the independent sector believed it was important to acknowledge and incorporate their cost structures into its calculations.	***2014/15*** • The system of national prices is designed to reflect differences in the complexity of different procedures. In cases where national currencies do not adequately reflect differences in complexity, our proposed rules for local variations allow providers and commissioners vary prices and currencies to reflect better these differences. ***Long term*** • In Subsection 5.1 of the consultation notice we note that prices should be cost reflective, but we also note that efforts to make prices more cost reflective need to be managed carefully. There is an important trade-off between efforts to improve the accuracy of cost information (that underpins pricing); and the need for the process to be as simple and transparent as possible. • We will consider these issues for future national tariffs. They are relevant to both price setting and for currency design.
7. Laparoscopic & open kidney and urethra procedures	• No negative comments on proposed prices for new laparoscopic/open kidney HRGs.	***2014/15*** • In light of this response, we have not changed our method from that set out in the TED. However, we have revised the text to make it clearer.

National variations

Topic: National variations		
Theme	**Feedback**	**Our response**
1: Support for proposed national variations	Respondents had a number of comments on proposals for national variations: • Clarify how pathway national tariffs that cross financial years are implemented. • On emergency admissions, strengthen and clarify guidelines regarding the reinvestment of readmissions penalty, the marginal rate and the emergency admissions marginal rate de minimums threshold. • Maintain stability of rules and provision for risk sharing agreements for 2014/15, but don't delay the development of alternative models of payment. • Maintain stability and do not change the Market Forces Factor and for specialist top-ups, but make the derivation of these rules more transparent. • Maintain the maternity risk share and keep the marginal rate for diagnostic imaging unbundling.	***2014/15*** • The maternity pathway will be reviewed as part of our work for 2015/16 • We have undertaken extensive analysis of the marginal rate rule and have made significant proposed changes to how it currently operates • For MFF and top ups we have not changed our approach for 2014/15, in line with our general "roll over" approach. We have provided further evidence where available. ***Long term*** • We will examine the risks and opportunities for multi-year payment approaches.
2. Specialist Top-Ups	• Three providers suggested that the list of eligible providers should be reviewed, and consideration be given to a specialist top-up for cancer services.	***2014/15*** • Although we received some comments, we did not receive any evidence to support the providers' proposals in this respect. Therefore, we have not proposed to change the value of specialist top-ups, the eligibility list, or the trigger list.
3. Maternity pathway	• Some negative comments were received on the complexity of the pathway. There was support to allow local risk sharing to continue in 2014-15 but strong support for signalling that 2014-15 will be the last year where this practice of locally agreed risk sharing is possible.	***2014/15*** • Maintain the current practice of locally agreed risk sharing; ask providers and commissioners to continue to make progress towards the national prices. • Additional guidance will be provided to support organisations

Topic: National variations		
Theme	**Feedback**	**Our response**
		to manage some of the maternity pathway data collection issues.
4. Diagnostic imaging	• Support to keep the marginal rate of 50% above trend growth in demand.	***2014/15*** • Under our proposals for 2014/15, commissioners and providers will continue to be able to manage the potential financial risk arising from the introduction of diagnostic imaging national tariffs.
5. Radiotherapy and chemotherapy	• Some comments that the national prices should not be rolled out until wider issues with the funding of cancer services have been resolved.	***2014/15*** • Providers and commissioners would have to use the national prices in 2014/15 unless doing so would create an unmanageable financial impact for either provider or commissioner. Our analysis has identified a very small number of health economies where a move to national prices in 2014/15 could have an unmanageable financial impact. In recognition of this, in 2014/15 these health economies would be exempted from using the full national prices but must move further towards using the national prices.

Local variations

Topic: local variations		
Theme	**Feedback**	**Our response**
1: Differing views on policy objectives of local variations	Respondents had a range of different views on the approach to local variations, their alignment with other mechanisms, and how they will be captured. On approach: • Concern that too much variation may undermine patient choice and/or allow commissioners to negotiate lower prices without service changes. • The approach for local variations should encourage for innovative payment approaches. • The approach should not be prescriptive or restrictive to support new models of care and new approaches should be allowed time for collection of an evidence base. • Support recognition that existing payment approaches have evolved for a reason, but transitional arrangements should be time limited. • Favour a framework of permissive principles (e.g., quality, integrated care, prevention, risk allocation) not prescribing narrow alternatives. • Maximum flexibility should be allowed (discounts and premiums to national prices, transitional funding, bundling/ unbundling) but not as a way to simply reduce spend by encouraging partnership working with Commissioners. • Local variations should focus on the big picture and clinically led changes to services that will bring clear benefits to patients. • On alignment with other mechanisms: incentives should be aligned across the system (e.g., GP	***2014/15*** • The proposed local variation rules are principle-based and therefore generally permissive in form, value and objective. • We will use scenarios to illustrate some of the innovative approaches that we are aware of. • We will collate local variation submissions (March - June 2014) and use these to assist future research and development into better payment models. • We will create a web-based search tool to help share practice. ***Long term*** • Monitor and NHS England will gather evidence from the use of local variations to inform the design of the payment system over the longer-term. It is likely that the design of the payment system will include some enduring flexibility, to ensure that innovation in clinical practice is not blocked. NHS England is also reviewing CCG allocations and the standard contract.

Topic: local variations		
Theme	**Feedback**	**Our response**
	contract). • Local variations should support integrated commissioning (Commissioners and local authorities). • Clarification is needed on whether public health and social care services are in scope • On collation and capture of local variations: Collect and review local variation agreements nationally and create a database for (i) good practice sharing and (ii) analysis of value for money to inform future national tariffs	
2: Request for further detail on implementation of local variations	Respondents raised a number of points with regard to the oversight and operation of local variations and their subsequent publication On oversight and operation: • What oversight will Monitor will provide on local variations? Will this address the "abuse" of the existing PbR system "flexibilities"? • How will learning and sharing local variations experience be encouraged? • What guidance will be provided on the steps to manage risk and risk sharing? • Will guidance be provided on how agreements could/ should be reached and a default, including how multiple commissioners / provider scenarios might work? • Will Monitor provide support to providers and commissioners failing to agree on local variations? Will Monitor accept "applications" from providers if co-operation with commissioners fails (as with local modifications)? • Will Monitor provide review of local variations that are	***2014/15*** • Local variations will not require permission from Monitor but we believe that it is appropriate that the relevant terms of local variations are published. • To assist in the disclosure, we are creating a standard submission template that overlaps with the required payment schedule in the 2014/15 standard contract. Users of the e-contract may be able to submit local variation summary at the same time. • The templates we have designed focus on disclosing the rationale for local variations and the use of constructive engagement, especially with clinicians. • Furthermore, we are planning education events to enable providers of commissioners to agree local variations, but Monitor will not provide case-based arbitration.

Topic: local variations		
Theme	**Feedback**	**Our response**
	agreed and self-certified locally? • Will there be a de minimus threshold for submission of local variations to Monitor? On publication • How do providers and commissioners with many existing flexibilities, publish existing agreements? Could their publication be staggered to control the initial burden of publication? • The publication of local variations to a general domain could be viewed as being commercially sensitive. What information and in what format will local variations have to be published and what will providers and commissioners need to demonstrate (e.g. rationale, improved outcomes etc).	
3. There are constraints on innovation in payment approaches	Respondents identified a number of constraints that inhibit innovation in payment approaches: • The risk of failure will discourage innovation/local variations • Short contracts will discourage longer term innovative local variations whereas using the national tariff as a tool for longer term planning will encourage adoption of local variations • Concerns about the availability of costing data, including benchmarking data to local commissioners for designing local variations • The status of commissioner and provider relationships • Local health economies not being able to afford the move away from block contracting • Alignment with contract timetable.	***2014/15*** • The publication timetable for the national tariff aligns with the contract timetable plan and this will be repeated in future years. (Assuming no Competition Commission reference) • Constructive engagement is a key principle proposed for local variations and supporting guidance will be published. ***Long term*** • We will examine the risks and opportunities for multi year payment approaches. • We believe improvements to costing data are vital. Therefore costing projects will be initiated on community, mental health, complex care, pathways and emergency care. This will inform the long term payment redesign.

Local modifications

Topic: Local modifications		
Theme	**Feedback**	**Our response**
1. Issues with the wider payment system that could have an impact on local modifications	• Local modification policy relies on national prices being accurate. There are concerns about HRG design and how complexities are recognised. • Other parts of the payment system particularly locally agreed prices may not be transparent enough for the process to work smoothly • Costing of services can be subjective. The coding, recording and submission process, to ensure data quality is standardised, may not be consistent across organisations.	***2014/15*** • Our approach to local modifications recognises that prices might not necessarily be appropriate for some providers and our policy is framed specifically to address this issue. • Further, a key part of our proposals is to introduce a greater degree of transparency into pricing arrangements that are currently determined at a local level. ***Long term*** • Our approach to the future payment system includes developments to improve the quality of cost information generally.
2. Clarification needed on policy	• Clarification is needed on the difference between local variations and local modifications • Clarification and definitions needed for the terms “value for patients”, “material deficit” and “organisational deficit” are required. • Concerns that the guidance documentation is too long and complex. • Clarification as to whether Commissioners will receive additional funding to meet the cost of a local modification • Clarification of methodology through greater use of worked examples required. • There may be a high volume of applications which are not supported by commissioners	***2014/15*** • We have sought to address these issues in our proposed method and supporting documents for local modifications. • We ask for feedback on the guidance and will refine new methods and guidance over time.

Topic: Local modifications		
Theme	**Feedback**	**Our response**
3. Concerns about incentives created by policy	• Trusts may use local modifications as a means of recovery, rather than managing costs. • Concerns over the stability of commissioners-provider relationships and so, too, their long term incentives.	***2014/15*** • We have sought to address these issues in our proposed method and supporting documents for local modifications, we will refine new methods and guidance over time.
4. Concerns over the additional requirements for applications	• Deficit criterion will incentivise providers to seek a local modification rather than reduce inefficiency and makes the policy reactive rather than proactive. • Concerns over whether an overall deficit is an appropriate criterion for local modifications. Some respondents suggested that local modifications should be based purely on structural issues because specific services may face structurally higher costs even when the provider is not in deficit. • Surpluses cannot be reinvested if they are being used to fund Trusts running deficits.	***2014/15*** • The deficit condition for local modification applications is intended to take into account cross subsidies where providers receive a price that is greater than cost for some services with national prices. In light of this, our approach is intended to focus Monitor's resources on cases where the refusal of commissioners to agree a local modification is most likely to pose a risk to patients. We consider this to be more likely where the provider is in significant deficit at an organisational level.
5. Concerns over the way local modifications fit into the annual cycle and their impact on investment decisions	• The process may be difficult to implement, as the agreements process is seen as too bureaucratic • Timescales required to sign off contracts, reports deficits, negotiate local modifications and apply are too tight. • Concerns over the time lag between the NTD release and the local modification agreement. • Local modifications cannot be used to fund new investments, which would stunt innovation.	***2014/15*** • The 2012 Act requires Monitor to introduce a regime of local modifications. As such we have sought to implement a regime that meets this statutory duty yet is proportionate in that it does not impose an undue burden on the sector. • The intent of local modifications is to provide additional funding to providers to compensate for unavoidably high costs that arise because of structural reasons at the provider. Other parts of the payment system can potentially be used to fund investment that can enhance innovation. ***Long term*** • We are planning to increase the time available for providers and commissioners to agree local modifications in the future.

Impact assessment

Topic: Impact assessment		
Theme	**Feedback**	**Our Response**
1. Data Quality	• The quality (and age) of the data being used for pricing calculations is not as good as it could be. • A number of additional data sources which would add value to the impact assessment calculations (such as PLICS).	***2014/15*** • For this year, we are using the latest available data (2012/13 where available). We are piloting the use of PLICS (Patient Level Information and Costing Systems) on a small scale but these will not feature in the calculation of prices for the *2014/15 National Tariff Payment System* under our proposals. It may, however, be a feature of subsequent years. ***Long term*** • We are already working on improvements to our impact assessment data sets for 2015/16 and subsequent years.
2. 30% Marginal Rate	• Impact analysis should be done on the scenario of removing the 30% Marginal rate rule.	***2014/15*** • We include changes to the marginal rate rule in our impact assessment. We have considered the impact on individual provider revenues as a result of using different baseline years. • Further detailed analysis on the marginal rate rule this decision can also be found in the slide pack, *Evidence gathered during Monitor and NHS England's review of the marginal rate rule* which we are publishing alongside the consultation notice.
3. Admin costs	• The impact assessment should include the impact of the proposed *2014/15 National Tariff Payment System* on administrative costs.	***2014/15*** • A key part of our impact assessment and our policy development more generally is to ensure that the costs of administering the system are proportionate to the benefits they create, yet are consistent with our legal obligations..
4. Affordability	• How is Monitor going to define affordability?	***2014/15*** • We do not define affordability. We replicate the Risk

Topic: Impact assessment		
Theme	**Feedback**	**Our Response**
		Assessment Framework tests that Monitor applies to Foundation Trusts and calculating these for each provider. In this way, each provider can assess their financial position against key financial tests already applied by Monitor to Foundation Trusts. • We also consider whether commissioners are likely to be bound by spending constraints, because this might have consequential impacts on patients.
5. Behavioural Responses	• Monitor should incorporate behavioural responses to the national tariff in its analysis.	***2014/15*** • Quantitative analysis of stakeholders' behaviour change will not be included in the 2014/15 impact assessment as, to produce meaningful analysis, will require a greater period of time than we had available in this first year of production. ***Long term*** • We will consider very carefully how behavioural analysis might be a feature of future impact assessments.
6. Business Rules	• The impact assessment should include all the Business Rules.	***2014/15*** • In 2014/15 we are aiming to capture as many Business Rules (for example, payments for excess bed days and specialist top ups) as possible, but it is not feasible to capture all of them. The nature of our proposals means that impacts on commissioners and providers will be reasonably consistent this year. ***Long term*** • Applying Business Rules will become more important if and when we make more specific changes to prices than those proposed for 2014/15. We will try to capture all the business rules that have a significant impact on providers and commissioners.

Topic: Impact assessment		
Theme	**Feedback**	**Our Response**
7. Commissioner Split (CCG vs. Specialist)	• Commissioners should be divided according to whether they are Commissioners or NHSE.	***2014/15*** • In our assessment we have analysed the impact of our proposals by CCG. We have not, however, analysed it by NHSE specialist commissioning. ***Long term*** • We will analyse in the impact on NHSE specialist commissioning.
8. Counterfactual	• The impact of the national tariff should be assessed over a longer time period than just one year.	***2014/15*** • The proposed national tariff would be valid for only 12 months. Therefore, we are assessing the impact of it over the period to which it applies.
9. Disaggregation	• Respondents said they would like to know the impact of the proposals for the *2014/15 National Tariff Payment System* on casemix and particular treatment pathways.	***2014/15*** • As already noted, we are not seeking to model changes in commissioner and provider behaviour as a result of changes in the national tariff in 2014/15 as we do not yet have a good enough understanding of the complex market dynamics of commissioning to do this with any degree of accuracy or confidence. ***Long term*** • Over the longer term we will consider the issues raised here.
10. Efficiency Requirement	• It was requested that the efficiency requirement be included in the impact assessment.	***2014/15*** • The impact of the efficiency requirement in the *2014/15 National Tariff Payment System* will be included in the impact assessment for 2014/15.
11. Financial tests	• A number of questions were raised about the financial tests that would be included in the 14/15	***2014/15*** • We are replicating the Risk Assessment Framework tests

Topic: Impact assessment		
Theme	**Feedback**	**Our Response**
	impact assessment including capital and balance sheet strength, PFI costs and sources of funding.	(Liquidity and Capital Servicing Costs) conducted on FTs and, in so doing, we will be assessing financial viability for all providers.
12. Health care integration	• Has the impact of the national tariff on the incentives to develop integrated care been considered?	***2014/15*** • We have assessed the impact of our policies on local variations, which are designed to ensure that that the payment system facilitates or, at the very least, does not act as a barrier to integrated care.
13. Individual providers and individual changes	• A variety of issues were raised about impacting individual changes, and expressing the impact of change on individual providers and commissioners.	***2014/15*** • The 2014/15 impact assessment will show the impact of most national tariff changes on individual providers and commissioning groups.
14. Local analysis	• Respondents questioned how the impact assessment would take account of local circumstances.	***2014/15*** • We have performed analysis on rural providers to ensure the proposed national tariff does not unduly impact the provision of healthcare services on rural communities. We are also assessing the impacts of local modifications and local variations which are specific policies designed to ensure that the national tariff has enough flexibility to deal with the unique circumstances of local health economies.
15. Non-PbR system Impact	• The impact assessment should assess the impact of the national tariff on non-PbR system areas of funding and services.	***2014/15*** • We have included the expected impact of the national tariff on non-national tariff (non-PbR) services. We expect that efficiency savings will be made across all functions and operations in a provider whether these underpin national tariff or non-national tariff services and we have modelled these changes when assessing the financial impact on providers. • For Commissioners with a fixed budget, we are concerned

Topic: Impact assessment		
Theme	**Feedback**	**Our Response**
		about the proportion of expenditure on national tariffed (PbR) services as a percentage of their total budget and therefore whether national tariff changes (on PbR services) are likely to squeeze spending on non-PbR services.
16. Overheads	• The current method potentially leads to providers over-recovering their overheads if volumes change.	***2014/15*** • The nature of a price-per-unit approach (such as the 2014/15 national tariff) is that providers with economies of scale can benefit from higher volumes. In some services this may be the appropriate approach, but in others the approach might depart from, over certain case load volumes, the principles we have set out in Section 5. However, to change the price-per-unit approach will require careful consideration and would not be consistent with our overall approach this year of "rollover". ***Long term*** • Departing from a price-per-unit approach will have significant implications for the sector. We will consider whether approaches might be appropriate (and for which services) in the longer term and with full engagement with the sector.
17. Patients and Outcomes	• Changes to the national tariff should only be approved if there is quantifiable benefit to patients. There was some concern on the qualitative evidence being used for capturing the impact on patient outcomes, and in addition whether there was quantitative evidence we could use.	***2014/15*** • Our impact assessment considers in detail the overall impact on patients of our proposals.
18. Performance Improvement	• The impact assessment should take account of how providers are performing against cost and quality improvement plans.	***2014/15*** • This has not been considered for *the 2014/15 National Tariff Payment System*. • The impact assessment considers the impact of changes to

Topic: Impact assessment		
Theme	**Feedback**	**Our Response**
		the national tariff on patients, providers and commissioners
19.Impact on specialist providers	• Many respondents provided suggestions for data sources that would allow for impact assessment on providers of specialist services.	***2014/15*** • The 2014/15 impact assessment assesses the impact on financial viability for all providers. 2014/15 impact assessment has not specifically examined specialist providers as a group. However, in accordance with the BIS guidance for impact assessment, we have considered the impact of our proposals on small providers, We have defined this as those providers with operating revenue of £200m or less in 2012.13. This group includes many specialist providers. ***Long term*** • In future years we hope to make use of more detailed data to allow for more subtle assessment of specialist providers.
20. Transparency and Communications	• Monitor should not rely on the previously used road-testing approach to stakeholder engagement for 2014/15. Stakeholders also requested that the national tariff for 2014/15 and associated impact assessment be published earlier in the year to allow it to be incorporated in to contracting decisions.	***2014/15*** • A new stakeholder engagement process was used which replaced the road-testing approach previously used by the DH PbR team. • Also, subject to a reference to the Competition Commission or a significant change to our proposals, we are intending to publish our final national tariff earlier in the financial year than has historically been the case.

Enforcement

Topic: Enforcement		
Theme	**Feedback**	**Our Response**
1. More clarity on investigation process	• Stakeholders broadly agreed with Monitor's principles for enforcement, but wanted more information on how Monitor will carry out the investigation and enforcement process in practice.	***2014/15*** • Monitor's *Enforcement Guidance* would set out in more detail Monitor's investigation and enforcement processes. In addition, Monitor plans to publish most of its enforcement decisions, which will, over time, create a bank of reference cases which will help facilitate understanding of our enforcement approach.
2. Informal action	• Respondents would like to encourage Monitor, the NTDA and NHS England to exhaust all informal action before enforcement via formal channels is carried out. Some respondents would also like Monitor and the other regulatory bodies to implement a feedback mechanism to help encourage compliance with the 2014/15 National Tariff Payment System.	***2014/15*** • We are committed to facilitating compliance with the new national tariff through the use of local variations. We will support sector participants to be compliant with the NT through engagement work on local variations and local modifications and, if necessary, by taking informal action where possible. • However, Monitor will adhere to the principles set out in the *Enforcement Guidance* when deciding when to take informal action. As such, the interests of service users will be the most important factor when deciding whether to take formal or informal action.

1.4 Stakeholders included in the engagement process

Earlier in 2013, Monitor and NHS England identified the parties having an interest in and influence on the payment system, to form a list of stakeholders for the national tariff engagement process. Primarily, this list comprised of:

- Clinical Commissioning Groups (and Commissioning Support Units);
- NHS foundation trusts;
- NHS trusts;
- independent NHS healthcare providers; and
- third sector NHS healthcare providers.

In addition, we identified other organisations or professionals who have a high degree of interest in and potential desire to influence the 2014/15 national tariff and whose views would be useful to NHS England and Monitor in this respect. These other parties are listed in Table 1B-8 below.

Table Annex 1B-8: Other parties invited to engage in proposals for the 2014/15 NTD

2020 Health	Academy of Royal Medical Colleges
Association of Chief Executives of Voluntary Organisations	Action against Medical Accidents
Action on Hearing Loss (RNID)	Adam Smith Institute
Addison's Disease Self Help Group	Age UK
Alzheimer's Society	Ambulance Service Network
Archant	Arthritis Care
Association of Ambulance Chief Executives	Association of British Healthcare Industries
Association of the British Pharmaceutical Industry	Asthma UK
Audit Commission	Barnardos
Bevan Brittan	British Medical Association
British Pregnancy Advisory Service	Breakthrough Breast Cancer
British Heart Foundation	British Journal of Healthcare Management
British Lung Foundation	British Society for Rheumatology
British Society of Hearing Aid Audiologists	Cambridge Economic Policy Associates

Cambridge Health Network	Cancer Partners
Cancer Research UK	Care & Repair England
Care Quality Commission	Centre for Policy Studies
Centre for Public Scrutiny	Centre for Workforce Intelligence
CentreForum	Chartered Institute of Public Finance and Accountancy
Chelsea and Westminster Health Charity	City University London
Competition Commission	Confederation of British Industry
Cystic Fibrosis Trust	Deloitte UK
Demos	Department of Health
Diabetes UK	Durham University
English Community Care Association	Epilepsy UK
Ernst & Young	Fabian Society
Federation of Opticians (FODO)	FT Network
General Medical Council	Grant Thornton
Healthwatch	Help The Hospices
Healthcare Financial Management Association	Imperial College London
Independent Healthcare Advisory Services	Institute for Fiscal Studies
Institute of Healthcare Management	INVOLVE
Joseph Rowntree Foundation	King’s Fund
King's Health Partners	KMCS
KPMG	Localis
London Voluntary Service Council	London Councils
London School of Economics	London School of Hygiene and Tropical Medicine
Macmillan	Marie Curie Cancer Care
Medicines and Healthcare Regulatory Agency	Mencap
MEND	Mental Health Foundation
Mental Health Network	Mental Health Providers Forum

Mills & Reeve LLP	MIND
Morgan Cole LLP	MS Society
National Association of Primary Care	National Association for Patient Participation
National Association for Voluntary and Community Action	National Association of LINKs members
National Council for Voluntary Organisations	National Pharmacy Association
National Trust Development Authority	National Voices
NESTA	Neurological Alliance
New Local Government	NHS Alliance
NHS Clinical Commissioners	NHS Confederation
NHS England (Area Teams)	NHS England (National)
NHS England (Regional Directors)	Health and Social Care Information Centre
NHS Litigation Authority	National Institute for Health and Care Excellence (NICE)
NHS Partners Network	Nuffield Foundation
Nuffield Trust	Optical Confederation
PA Consulting	Patient Concern
Patient Opinion	Patients Association
Parliamentary and Health Service Ombudsman	Policy Exchange
Primary Care Commissioning	Primary Care Foundation
Private Hospitals Alliance	PwC
Queen Mary, University of London	Royal College of General Practitioners Centre for Commissioning
Rethink	Richmond Fellowship
Richmond Group	Ridouts LLP
RNIB	Royal College of General Practitioners
Royal College of Midwives	Royal College of Nursing
Royal College of Obstetricians and Gynaecologists	Royal College of Ophthalmologists
Royal College of Physicians	Royal College of Radiologists
Royal College of Pathologists	Royal College of Speech and Language Therapists

Royal College of Surgeons in England	Royal Pharmaceutical Society
South West London Cancer Network	Stroke Association
The Disabilities Trust	The Health Foundation
UCL Partners	University of Cambridge
University of East Anglia	University of Surrey
University of Warwick	University of York
York University Health Policy Group	