National Tariff 2014/15 An Engagement Document

13 June 2013

Publications Gateway Reference Number: 00174

NHS England INFORMATION READER BOX		
Directorate		
Medical Nursing **Finance**	Operations Policy Human Resources	Patients and information Commissioning Development
Publications Gateway Reference: 00174		
Document Purpose	Resources	
Document Name	**National Tariff 2014/15 An Engagement Document**	
Author	NHS England and Monitor	
Publication Date	13 June 2013	
Target Audience	CCG Clinical Leaders, CCG Chief Officers, CSO Managing Directors, Care Trust CEs, Foundation Trust CEs , Medical Directors, Directors of Adult SSs, NHS Trust Board Chairs, Directors of Finance, NHS Trust CEs	
Additional Circulation List	N/A	
Description	The document has two main purposes. First, it explains to sector stakeholders our proposed approach to developing our first National Tariff for NHS services for 2014/15. The *National Tariff Document* (NTD) will replace the annual *Payment by Results Guidance* formerly produced by the Department of Health. Our second aim is to encourage readers to send us their views on the principles and details of our approach. We can then reflect your views in the statutory consultation on the National Tariff, which will take place in the autumn, and in the National Tariff itself, which we intend to publish at the end of this year or early in 2014.	
Cross Reference	N/A	
Superseded Docs	N/A	
Action Required (if applicable)	N/A	
Timing/ Deadlines (if applicable)	**Deadline for responses is 9th July 2013**	
Contact Details for further information	Susan Devlin NHS England Room 2S07, Quarry House Leeds LS2 7UE	
Document Status	This is a controlled document. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of this document are not controlled. As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the intranet.	

National Tariff 2014/15: An Engagement Document

Contents

Foreword

NHS England and Monitor formally assumed joint responsibility for the payment system for NHS services in April 2013. This document is the first technical communication to come out of our new partnership.

The document has two main purposes. First, it explains to sector stakeholders our proposed approach to developing our first National Tariff for NHS services for 2014/15. The *National Tariff Document* (NTD) will replace the annual *Payment by Results Guidance* formerly produced by the Department of Health. Our second aim is to encourage readers to send us their views on the principles and details of our approach. We can then reflect your views in the statutory consultation on the National Tariff, which will take place in the autumn, and in the National Tariff itself, which we intend to publish at the end of this year or early in 2014.

Over time, our shared aim for the NHS payment system is that it should support continually improving quality of care for patients as sustainably as possible, with any risks shared appropriately between providers and commissioners. Developing the 2014/15 National Tariff is a first step on a long journey. During this time of change for the NHS, we recognise that commissioners and providers need the payment system to be predictable. So for 2014/15, we propose to keep the list of nationally mandated services and their relative prices broadly stable compared to 2013/14.

Please tell us what you think of our proposed approach set out in this document to:

- planning the structure of the *National Tariff Document*;
- determining the 2014/15 tariff;
- setting out variations to national prices and rules for local price setting;
- determining and approving local modifications;
- enforcing the National Tariff; and
- assessing the impact of our proposals.

At every step of the journey towards an NHS payment system that does all it can to serve patients well, we are depending on commissioners and providers telling us how you think our proposals will work in your locality, and how to improve them. We look forward very much to hearing your views and discussing with you how to make the payment system do more for patients.

Paul Baumann
Chief Financial Officer
NHS England

Adrian Masters
Managing Director, Sector Development
Monitor

Executive summary

The Health and Social Care Act 2012 (the "Act") gives Monitor and NHS England responsibility for designing and implementing the reimbursement framework for NHS-funded health care services from 2014/15. Our respective duties place an emphasis on putting the patient at the heart of our decision-making, ensuring services are delivered to a high quality, as sustainably as possible.

Providers of NHS hospital, mental health, and community health services are currently reimbursed by commissioners through a combination of tariff prices for individual services (both national and local) and block contracts for groups of services. The system of National Tariff prices, known as Payment by Results, was previously administered by the Department of Health. Under the new regime, Monitor and NHS England have joint responsibility for setting national prices, as well as for determining the rules governing local price-setting negotiations.

In future, Monitor will publish a *National Tariff Document* (NTD), which will set out both National Tariff prices and rules and guidance for local pricing. The NTD will therefore underpin reimbursement of NHS-funded health care.

Before Monitor publishes the NTD, the Act requires Monitor to consult with providers, commissioners and other interested parties by publishing a "notice". This notice must set out Monitor's proposals for the National Tariff, including the national prices that will apply to some services, the method used to determine those prices, and the rules and variations for local price-setting.

We are keen to engage with commissioners, providers and other interested parties early, before we issue the statutory consultation notice in the autumn. This notice will set out our final detailed proposals and will not contain options for consideration. If, as a result of this consultation, we were to make material changes to the National Tariff proposals contained in the notice, a further period of statutory consultation is likely to be required. For this reason this engagement period is the main opportunity to contribute to the development of the 2014/15 National Tariff proposals in a timely way that would not delay issue of the final *National Tariff Document*.

This engagement document therefore sets out our proposed approach to the 2014/15 National Tariff and highlights the key issues on which we would welcome the views of commissioners, providers and other interested parties over the next few weeks.

Monitor intends to issue the statutory consultation notice this autumn. When the notice is issued, the Act gives commissioners and providers the opportunity to object formally to the method set out in the notice that Monitor proposes to use to determine national prices. If a sufficiently large proportion of either providers or commissioners object to the method proposed in the statutory consultation notice, Monitor must either revise the method and consult with the sector again or refer the proposed method to the Competition Commission to determine if it is appropriate. If Monitor does not receive objections above the prescribed levels or new information triggering a delay, we plan to publish the NTD, which includes prices for 2104/15 before the end of December 2013. Early publication will give commissioners and providers more time than in previous years to negotiate contracts and prepare plans.

This document is about the payment system for NHS health care services for 2014/15 only. However, we are also separately considering how to develop the payment system in the longer term and the scope for wider-ranging, more substantial changes that could be introduced from 2015/16 onwards. In May 2013 we published a discussion paper *How can the NHS payment system do more for patients?* to start a dialogue with the sector about the longer term direction of the payment system. We will look to develop proposals for the payment system which are aligned with other proposals to be developed in the NHS Strategy work recently announced by NHS England. Our shared aim is that the payment system for the NHS supports continually improving quality for patients as sustainably as possible, with risks shared appropriately between providers and commissioners.

There are six main topics covered by this engagement document:

1. The proposed structure of the *National Tariff Document* (NTD)

The range of documentation published by the Department of Health to support the payment system for NHS-funded services has inevitably grown over time. The transfer of responsibility for the system to Monitor and NHS England presents a useful opportunity to review the documentation and look for sensible ways to present our regulations.

Our main proposal, described in section 2, is to have a relatively short main NTD providing a single, overarching explanation of the system of payment. This will be supported by more detailed annexes, guidance and other supplementary documents published within or alongside the NTD. Our objective is that the NTD should be a working document: straightforward; easy to navigate; and practical for commissioners, all types of provider and other interested parties to use.

2. The approach to the 2014/15 tariff

Our overall approach to the 2014/15 tariff has been influenced by two concerns. First, the NHS is already going through extensive change in this year of transition. Therefore to provide additional certainty for the sector, our overall approach to the tariff for 2014/15 is to keep relative prices broadly stable and to seek to publish prices earlier in the year. Second, the new legislation both transfers responsibility for the tariff to new bodies and sets out in detail a new process for price setting, which requires decisions to be made earlier in the year. These changes create operational risks in this transition year which we have sought to manage by limiting the number of detailed changes.

As in previous years, the prices for health care services will be based on reference costs. However, we know the quality of the submitted cost data varies, and this may have been one factor behind the significant variation year-on-year in prices for some services. Organisations tell us that this variation is destabilising and hinders long-term service planning. During 2013 we are running some pilots to evaluate alternative methods of collecting cost data at patient level. Over time we hope this will provide a reliable basis for informing price regulation in future. In the meantime, we propose to use the 2013/14 prices as the basis for setting the 2014/15 tariff rather than determining new prices based on updated reference cost data.

We will need to amend the 2013/14 national prices to take into account cost inflation and projected efficiency gains. Various factors may push up costs for efficient providers during the course of the year. These include pay settlements, pay drift, drug costs, and the cost of

the Clinical Negligence Scheme for Trusts (CNST). Section 3 of this document sets out the data that we propose to use in order to derive the overall adjustment for inflation. At this stage, we do not have the exact figures for all of the relevant cost factors and some will still be unavailable in the autumn when we publish the statutory consultation notice. However, we set out here the information sources we intend to rely on for the cost factors we will use to calculate the inflation adjustment. We welcome your comments on these information sources.

We will also need to include expected unit cost efficiency improvements in the national price calculation for 2014/15. Section 3 of this document sets out how we propose to determine the efficiency gains that we expect providers to deliver in 2014/15 and how these gains will be factored into the 2014/15 prices. Depending on the assumptions used in our proposed methodology, our efficiency factor should be in the range of 3% and 4.5%.

While our overall approach to 2014/15 is to maintain a stable tariff to reduce uncertainty and risk in this year of transition, we need to ensure that the 2014/15 tariff is still clinically relevant and sufficiently up-to-date. For this reason, we propose to make a number of additional changes which include introducing a limited number of new services with associated prices, and amending a small number of existing prices.

3. Variations to National Tariff prices and rules for determining local prices

As well as setting out the core regulated national prices, the current payment system includes many variations, that is, rules that allow contracting parties to vary those prices or determine new payment approaches, as well as mandatory adjustments such as the Market Forces Factor (MFF) which adjusts for unavoidable variation in certain costs faced by providers. These variations mean actual prices paid to providers differ from the national prices.

The Act provides for a number of types of rules and permitted variations to prices from 2014/15. The national prices, together with those rules and variations, will constitute the statutory National Tariff. In line with our objective of keeping the tariff stable next year, we propose to roll forward many of the existing rules and permitted variations unchanged from the 2013/14 tariff to the tariff arrangements for 2014/15. Mapping the existing types of rules and variations onto the new statutory National Tariff will help increase the transparency of local price setting. This approach leaves substantial scope for flexibility in the determination of local prices and allows innovation in service provision. Over time we will look at how rules and variations can increase the transparency of pricing and ensure that appropriate incentives are provided to commissioners and providers.

Section 4 of this document sets out the changes in the Act to the permitted types of rules and variations to prices. It also sets out how existing types of rules and variations map onto the new framework and our proposals to amend or review a small number of variations and rules.

The 2013/14 tariff introduced some changes to rules for payment for particular services such as maternity and diagnostic imaging. We need to consider the approach to adopt for those services in the National Tariff for 2014/15. Although we realise it is still too early in 2013/14 for much data to be available, we welcome users' views on the impact of these changes introduced in April 2013 and how they should be managed in the 2014/15 tariff. We are also

examining options for how we link the implementation of mental health currencies to incentivising quality care.

We are also undertaking reviews of two high-profile areas: the 30% marginal rate rule and local payment variations (previously known as flexibilities). Due to the significance of these two rules we are undertaking supplementary engagement on these. We issued a call for evidence on the 30% marginal rate rule on 13 May and we are publishing a discussion paper on local payment variations at the same time as this document (see www.monitor.gov.uk/pricing).

4. Local modifications

The Act creates a new framework for local modifications of national prices in circumstances where providing the services in question at the national price would be uneconomic for the provider. If a commissioner and a provider agree on a modification following rules set by Monitor and if that modification is submitted to, and approved by, Monitor, it is known as an "agreement". Alternatively, where a commissioner and provider fail to agree, a provider may apply to Monitor for a local modification to national prices. This is termed an "application". The method used for deciding whether to approve an agreement or grant an application must be set out in the NTD, and the proposed method for 2014/15 will be set out in the autumn statutory consultation notice.

Local modifications are not intended to subsidise inefficient providers. We propose to limit local modifications to situations where a service is uneconomic because the provider faces structurally higher costs than those reimbursed by the national price. By structurally higher we mean for reasons *outside* the provider's control and not reasonably addressed elsewhere in the reimbursement system (for example, through the MFF).

We intend to adopt a balanced and proportionate approach to assessing whether a particular service is uneconomic. However, it will be for those proposing a local modification to demonstrate with evidence that there is a genuine structural reason for their higher costs. To take into account the possibility of cross-subsidies arising from the National Tariff, we propose that, initially at least, we will only consider *applications* for local modifications from a provider that is in material deficit overall. This approach will also focus resources on the highest priority cases.

This document sets out the new legal framework for agreements and applications for local modifications in Section 5. We also set out our proposed approach to determining whether the provision of services is uneconomic, the criteria against which we propose to assess agreements and applications, and the process we intend to follow. Our proposed policy rules and the supporting evidence required are set out in Appendix B (see www.monitor.gov.uk/pricing). We invite comments on all of these proposals.

5. Enforcement of the National Tariff

The Act introduces an enforcement regime for the National Tariff and gives Monitor responsibility for applying it. In addition, the NHS Trust Development Authority (NHS TDA) will have a role in enforcing the National Tariff among NHS trusts. Monitor has separately published draft guidance on enforcement of the National Tariff for consultation. This sets out the statutory framework and the approach to enforcement that Monitor and the NHS TDA

propose to adopt. Monitor intends to decide on its priorities for enforcement action by considering the likely costs and benefits of investigating cases.

The consultation on the draft enforcement guidance (see www.monitor.gov.uk/pricing) follows the same timetable for engagement as this document. Having listened to the sector's views we aim to publish final enforcement guidance alongside the *National Tariff Document*. Section 6 of this document briefly sets out the enforcement framework and directs readers to the full guidance consultation.

6. Impact assessment

When we publish our consultation on the proposed National Tariff in autumn 2013 we will include an impact assessment of the proposed changes, in accordance with our duties under the Act. Appendix A (see www.monitor.gov.uk/pricing) to this document sets out our approach to conducting that impact assessment. We consider that the changes to specified services proposed for the 2014/15 National Tariff are relatively small in terms of the number of patients affected and the value of services. Our estimates suggest these proposed changes to services will not make a material impact on any individual provider. The main focus of the impact assessment will therefore be on the impact of the overall adjustments to the tariff for inflation and efficiency improvements. We would welcome your views on our approach to the impact assessment. As required under the Act, we will formally consult on the published impact assessment, alongside the consultation on the tariff notice itself.

Feeding in your views

NHS England and Monitor are committed to developing the National Tariff so that it helps commissioners and providers to deliver efficient, high-quality services to patients. Your views on the issues raised in this engagement document will help us to improve our approach. We welcome your views on the specific questions in this document. We also hope that you will share your thoughts with us in the forthcoming webinars and regional workshops we are organising to engage interested parties in shaping the National Tariff for 2014/15.

Please respond to the general and detailed questions raised and provide more general comments by completing the web based response form by **5pm on Tuesday 9 July 2013**.

1 Introduction

The Health and Social Care Act 2012 (the "Act") gives Monitor and the NHS Commissioning Board, now known as, and referred to in this document as, NHS England, responsibility for designing and implementing the reimbursement framework for NHS-funded health care services. Our respective duties place an emphasis on putting the patient at the heart of our decision-making, ensuring services are delivered to a high-quality, as sustainably as possible.

Providers of NHS hospital, mental health, and community health services are currently reimbursed by commissioners through a combination of tariff prices for individual services (both national and local) and block contracts for groups of services. The system of National Tariff prices, known as Payment by Results (PbR), was administered by the Department of Health (DH). Under the new regime, Monitor and NHS England will have joint responsibility for setting national prices, as well as for determining the rules governing local pricing negotiations.

In future, Monitor will publish a *National Tariff Document* (NTD), which will set out both National Tariff prices and rules and guidance for local pricing. The NTD will therefore underpin reimbursement of NHS-funded health care.

Before we publish the NTD, the Act requires Monitor to consult with providers, commissioners and other interested parties by publishing a "notice". This notice must set out Monitor's proposed National Tariff, including the national prices that will apply to some services, the method used to determine those prices and the rules for local variations. Furthermore, the Act gives commissioners and providers the opportunity to object formally to the method that Monitor proposes to use to determine national prices. If we receive objections from a sufficiently large proportion of either providers or commissioners, Monitor must either revise the method it has used and consult with the sector again, or refer the proposed method to the Competition Commission to determine whether it is appropriate.

We are keen to engage with commissioners, providers and other interested parties now, before issuing the statutory consultation notice. By engaging at this stage, we hope to understand any issues that providers and commissioners have and consider their views, to ensure that we are taking a fully informed approach to determining the 2014/15 National Tariff. Active engagement now will also help us avoid unnecessary delay to the publication of the 2014/15 NTD.

The purpose of this document therefore is to set out our proposed approach to the 2014/15 National Tariff, and seek your feedback. As part of this, we explain the proposed changes to the process of setting the tariff introduced by the Act and set out the methodology we propose to use to determine the 2014/15 national prices. We welcome your views on all aspects of our approach, but ask a number of specific questions in areas where we would particularly value your feedback.

This engagement document has been produced and published jointly by Monitor and NHS England. Generically through the document the terms 'we' and 'our' are used to refer to both Monitor and NHS England. However, Monitor and NHS England also have distinct roles, duties and responsibilities and so, where possible, we have tried to make clear in the text where a specific role or responsibility falls to either Monitor or NHS England respectively.

1.1 The feedback and engagement process

Our primary aim in issuing this document is to engage with stakeholders. You will therefore be able to give us your comments and feedback through a number of different channels.

To assist you in providing responses to this document we have divided the questions into two types:

- **general questions** that we expect all respondents are likely to wish to answer in their engagement responses. These questions are numbered as Q1, Q2,...Q11; and
- **detailed questions** relating to particular rules or areas of evidence on which we are seeking feedback. We hope to receive feedback from as many respondents as possible on these questions but recognise that some of these questions may not be relevant to some respondents. These detailed questions are numbered DQ1, DQ2,...DQ22.

All of the questions are listed in **Section 7** as well as at the appropriate point throughout the document**.**

You can respond to the general and detailed questions raised and give more general comments by completing the response form.

Monitor and NHS England will also be hosting a series of regional joint NHS pricing and incentives workshops for commissioners and providers in July 2013 to discuss our approach to the 2014/15 National Tariff. The workshops will be held in:

- London on 1 July 2013
- Leeds on 3 July 2013
- Leicester on 9 July 2013
- Newbury on 17 July 2013

If you would like to register your interest to participate in one of these workshops please do so here.

We will also be holding webinars to discuss our approach to local payment variations. These will be held on:

- 26 June 2013
- 27 June 2013
- 4 July 2013

If you would like to express an interest in attending, please go to www.monitor.gov.uk/pricing.

1.2 This document

There are six further sections of this document and four appendices.

In **Section 2**, we set out the proposed scope, structure and content of the 2014/15 NTD. We then go on to describe the legal framework and the statutory consultation process that will underpin the tariff publication process.

In **Section 3**, we set out the policy approach NHS England and Monitor have adopted for our first tariff. We outline proposed changes to the set of services covered by the National Tariff for 2014/15. For those new or amended services for which we propose to set a national price, we set out how we propose to determine that price. We also set out our proposed method for determining 2014/15 prices more generally.

In **Section 4**, we define the types of rule and variations permitted under the Act and set out some proposals for the rules and variations for 2014/15. We also set out how the existing rules and variations of the PbR system would translate across into the new framework.

In **Section 5**, we set out how the new Local Modifications regime would operate and describe the legal basis underpinning the Local Modifications framework.

In **Section 6**, we briefly describe how Monitor will enforce the National Tariff with commissioners and providers. Monitor is consulting on draft guidance on enforcement of the National Tariff. Details of the consultation can be found at www.monitor.gov.uk/pricing

In **Section 7**, we set out a full list of the questions on which we are seeking views in this engagement process.

There are also four appendices to this document.

Appendix A sets out our approach to the Impact Assessment of the National Tariff. This appendix explains, at a high level, the objective of impact assessment and our legal obligations in this area. More specifically, we describe our approach in relation to the 2014/15 National Tariff and the anticipated impact of service changes and inflation and efficiency adjustments on specific commissioners and providers.

Appendix B sets out the details of the proposed rules governing Local Modifications.

Appendix C presents the detailed specification of the limited number of HRG design changes proposed for 2014/15.

Appendix D: contains a mapping of the DH PbR 2013/14 documentation to the proposed 2014/15 NTD. It is important to ensure that those involved in using and applying the DH PbR 2013/14 tariff have sufficient information to understand the relationship between that tariff (currently in force) and the new 2014/15 NTD. With this in mind, we have mapped the components of the DH PbR 2013/14 tariff to the 2014/15 NTD, so that the reader can see where the relevant guidance sits in the new document or if the Act supersedes the old requirement.

1.3 Other documents / resources

Alongside this engagement document we are publishing a discussion paper on local payment variations and as set out in Section 6 Monitor has published a consultation document on *Draft Guidance on the Enforcement of the National Tariff*.

Local payment variation rules govern how providers and commissioners may vary national currencies and prices to the benefit of patients. The discussion paper seeks views on specific questions concerning: appropriate objectives for local payment variations; what can be done to overcome issues identified to date with implementing local payment variations; and reporting and oversight of local payment variations in practice.

There is also a range of other documents and resources which the reader may find helpful in placing this engagement document in context. These include:

- *How can the NHS payment system do more for patients?* A discussion paper published by NHS England and Monitor on 13 May 2013 on the future strategy for the payment system.

- The call for evidence on the *Emergency admissions marginal rate review* issued on 13 May 2013.

- The Engagement Grouper[1] published alongside this engagement document.

- The PbR Guidance for the 2013/14 National Tariff.

[1] The Grouper is software produced by the Health & Social Care Information Centre to map activity data (coded as operation & procedure and/or diagnosis codes) to HRGs. The grouper software does not apply exclusions or tariff prices. For more details and/or to download the current Grouper, please see: http://www.hscic.gov.uk/casemix/downloads.

2 The *National Tariff Document* 2014/15

As explained in the previous section, for 2014/15 Monitor and NHS England are developing the first *National Tariff Document* (NTD) that will govern the system of reimbursement for NHS-funded health care services. We are taking over this role from the PbR team in the Department of Health and the NTD will replace existing PbR documentation and guidance.

The Act specifies certain components which must be included in the NTD and other components which may be included. The Act also mandates a process of statutory consultation that must be undertaken before the final NTD can be issued. If a sufficiently large proportion of either commissioners or providers object to the proposed method for determining national prices, Monitor must either make amendments to the method and repeat the statutory consultation process, or refer the National Tariff to the Competition Commission.

This section explains the scope of the NTD, the process for consultation with relevant stakeholders, how commissioners and providers may object to the proposed method for determining national prices and how we propose to structure the consultation notice on the *National Tariff Document*.

2.1 Scope of the *National Tariff Document*

From 2014/15 Monitor must publish a document known as "the National Tariff". This document must set out the health care services provided for the purposes of the NHS which NHS England and Monitor agree are to have a national price, the method for determining those prices, and the method for assessing local modifications to those national prices. The document may also include rules at a national level that vary national prices, rules for local variations, and rules for the local determination of prices payable for services which do not have a national price.

Under the Act, all payments by NHS commissioners for the provision of NHS services may be covered by the National Tariff. However, the National Tariff must be consistent with current legislative requirements relating to payment – for example the 2013 NHS regulations and directions for GMS and PMS contracts[2]. We therefore do not intend to cover these separate payment systems in 2014/15 and the NTD will be clear that these continue to be standalone for the year.

However, as care becomes more integrated across different services, we will need to ensure that the National Tariff includes appropriate rules to govern the payment of services that potentially span multiple care settings or existing administrative boundaries. This might mean that, in the future, there will be rules covering local price setting for integrated care services that bring together primary, acute, mental health and community care. We will want to make sure these rules allow NHS commissioners to pool budgets or enter into lead commissioning arrangements with local authorities, where there is a local desire to integrate health and social care to deliver better outcomes for patients.

[2] General Medical Services (GMS) and Personal Medical Services (PMS)

The National Tariff will not apply to public health services provided or commissioned by local authorities or Public Health England, or to public health services commissioned by NHS England under its "section 7A agreement" to exercise certain Secretary of State public health functions.

2.2 Process for statutory consultation

There are prescribed steps that Monitor must follow before it can issue the NTD. Monitor must set out its proposals for the National Tariff in a consultation "notice" and receive objections to that notice. In the light of the number and content of any objections it receives and other comments or views there are three possible outcomes to the consultation on the notice. These are that Monitor either:

- issues the National Tariff on the basis of the proposals contained in the consultation notice; or
- consults again on a revised notice; or
- makes a reference to the Competition Commission.

Monitor intends to issue the consultation notice in the autumn of 2013. If Monitor does not decide to re-consult, and there is no reference to the Competition Commission, it would intend to publish the final NTD in December 2013.

The formal steps, prescribed in the Act and relevant regulations, that Monitor must follow are set out below.

2.3 The 'method' to which an objection can be made

Under the statutory objection process in the Act, what CCGs and relevant providers may object to is defined relatively narrowly as 'the method or methods Monitor proposes to use to determine national prices' for health care services specified in the National Tariff. The method we set out will specify the source data and steps in the calculation of national prices for relevant services.

The relevant 'method' to which an objection may be made does not therefore include, for example:

- the design of currencies[3];
- the decision whether or not to include particular services in the National Tariff;
- the specific level of any national price;
- any variations or rules applied to local and national prices.

Each of these fall outside of the scope of the objection process and therefore cannot form the basis of a formal objection for the purposes of the statutory process.

[3] A currency is the unit of health care for which a payment is made and can take a variety of forms. Healthcare Resource Groups (HRGs) are one of the commonly used forms of currency.

Statutory process of consultation and objection

The Act requires that, before publishing the ***National Tariff Document***, Monitor must send a "notice" with the proposals for the National Tariff to each Clinical Commissioning Group (CCG), each "relevant provider" and any other such bodies or individuals that Monitor considers appropriate.[4] This statutory consultation notice must set out the components of the proposed NTD.

A consultation period of 28 days follows the publication of this notice, during which CCGs and relevant providers are able to object to the proposed method for determining national prices set out in the consultation notice. Monitor will publish details of how CCGs and relevant providers can object to the method proposed for determining national prices at the same time as the notice.

If certain objection thresholds are reached during the statutory consultation, Monitor will be unable to publish the final NTD. These thresholds are:

- The proportion of CCGs who object is equal to or greater than the 'prescribed' percentage;
- The proportion of relevant providers is equal to or greater than the 'prescribed' percentage ('the objection threshold'); and
- The 'share of supply' of those providers who object is equal to or greater than the 'prescribed' percentage (the share of supply threshold').

The 'prescribed' percentage and 'share of supply' will be defined in the relevant regulations.[5] In the draft regulations, the prescribed percentage is 51%.

If, after the consultation period of 28 days, any of the objection thresholds are reached, Monitor will be unable to issue the NTD unless it either makes changes to the method and re-consults using the same statutory process as detailed above or makes a reference to the Competition Commission for it to determine whether the method proposed in the notice is appropriate.

According to the Act only objections from CCGs and "relevant providers" can determine whether Monitor can proceed with publication of the NTD. The Act allows relevant providers to be defined as either:

(a) Providers which hold a licence issued by Monitor under Part 3 of the Act (for the purposes of consultation in 2013, this means Foundation Trusts); or

(b) Any other provider described in regulations made by the Secretary of State under the Act.[6]

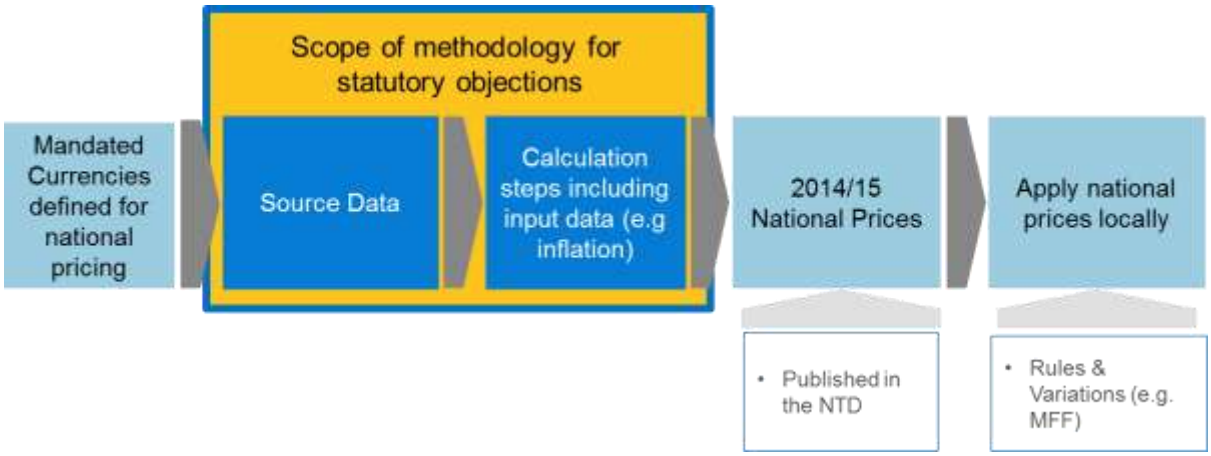
[4] Health and Social Care Act 2012, Part 3, Chapter 4, s.118

[5] The relevant draft regulations are the National Health Service (Licensing and Pricing) Regulations 2013 available at http://www.legislation.gov.uk/ukdsi/2013/9780111539743

[6] The relevant regulations are currently in draft and subject to approval by Parliament. In the draft regulations all providers of NHS services for which there is a national price proposed in the consultation notice would be "relevant providers" – this includes foundation trusts and NHS trusts, as well as private and voluntary sector providers. Objections from these providers will all count towards the 'objection threshold'. However, in calculating the 'share of supply' threshold, providers' objections are considered only if they provide services for which a national price is specified in the proposed tariff *and* the current national tariff.

However, in addition to registering statutory objections to the proposed method for determining national prices, CCGs and relevant providers may also comment on any other part of the notice. These comments would not form part of the statutory process under which the method may be referred to the Competition Commission. However, we will, of course, carefully consider comments and feedback on any aspects of the payment system in response to the National Tariff consultation notice.

Figure 2-1 Scope of the method for objections



2.4 Structure of the *National Tariff Document* and supporting documents

As we have already noted, the Act requires that Monitor must publish a *National Tariff Document*[7]. It specifies that the NTD must contain certain provisions, but it also allows some discretion for Monitor and NHS England to include other provisions if they so choose. For example, the NTD must include the specification of certain health care services provided for the purposes of the NHS, the method or methods used for determining the national price of those services, and the national price of each of those specified services. In addition the NTD must include the method for deciding whether to approve a local modification and for determining an application for a local modification.

By contrast, Monitor and NHS England may exercise discretion over whether to specify within the NTD rules and variations to national prices, we may also publish guidance on the application of the national variations, the rules and on any method of local modification. The permitted rules and variations include:

- national variations to national prices (eg the Market Forces Factor);
- rules for local variation of regulated national prices and mandated currencies (previously known as 'flexibilities');
- rules for local price setting for services which are not subject to national pricing (including the specification of mandated currencies with no regulated national price, eg Ambulance Services); and
- payment rules (eg relating to operational issues, such as invoicing).

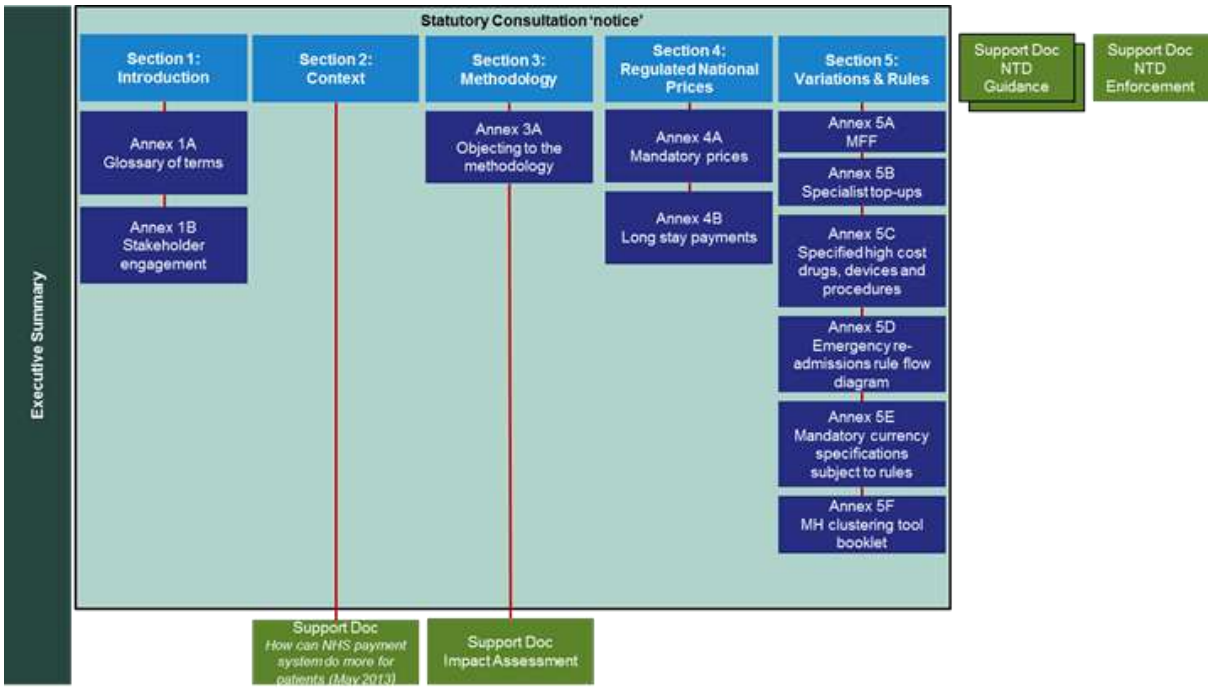
[7] Health and Social Care Act 2012, Part 3, Chapter 4, s.116 (1)

Alongside the NTD, we propose to publish a number of additional supporting documents, including an executive summary, additional non-statutory guidance to support users of the NTD in its practical application, an impact assessment, and guidance on enforcement.

2.4.1 The proposed structure of the consultation notice and NTD

Our proposed structure for the *National Tariff Document* and the 'notice' we must publish for statutory consultation is set out in Figure 2-2 below. We believe this structure will help readers to understand the legal basis for each component of the NTD and make clear for providers and commissioners what constitutes the relevant 'method' for the purposes of determining regulated national prices. We propose that the structure of the National Tariff consultation notice will closely mirror the structure of the final NTD. The proposed structure set out below therefore applies to the consultation notice but also reflects with small modifications the proposed structure of the NTD.

Figure 2-2 Proposed structure of statutory consultation "notice"



The **introduction** will set out the roles of Monitor and NHS England in pricing and reimbursement and articulate the legislative context of the NTD. It will also provide a guide to the structure of the rest of the document. A glossary of terms used within the consultation notice (and final NTD) will be attached to the introduction as an annex. We will also include a summary of the responses to this engagement as an annex to the notice (but will not include this in the NTD itself).

The **context section** will cover the overall strategy and principles for pricing. This section will provide some details of our long-run aspirations for the role of pricing in ensuring the efficient delivery of quality services to patients. The section will also provide detail on proposed future changes to the payment system and current projects that may lead to change.

The **methodology section** will set out in detail the method used to determine the regulated national prices for mandated currencies. We will also include as an annex to the notice the process for objecting to the proposed method for determining national prices.

The **section on regulated national prices** will describe the mandated currencies for health care services provided for the purposes of the NHS, including 'best practice tariffs'[8]. It will also include, as an annex, the list of regulated national prices of those currencies as determined using the method or methods set out in the methodology section.

The **variations and rules section** will cover all other mandatory elements of the payment system not covered by regulated national prices. We propose that technical detail around variations and rules will be presented in annexes to this section, and the variations and rules will be supported by full explanations to ensure their correct application. Mandated currencies that currently have no regulated national price will fall within this section (eg Adult Mental Health services). Where appropriate, we will also provide accompanying guidance for commissioners and providers to assist with the implementation of the rules and set out any established good practice. In some cases, "how to" guides and good practice guidelines will need to be developed and published at a later date.

2.4.2 The proposed structure of the supporting documentation

The 'notice' and the final NTD will be accompanied by a range of supporting documents. We plan to include the recent discussion paper *How can the NHS payment system do more for patients?* alongside the context section. We will also include views from stakeholders following this engagement exercise. In support of the methodology section, we will present the impact assessment of the proposed changes to the National Tariff. We propose that the guidance on enforcement of the National Tariff will sit as a supporting document, outside the NTD itself.

In previous years, the 'PbR Guidance' was used as an overarching document to set out policy, PbR rules, operational guidance, currency explanations, and payment and reporting rules. To make it easier for users to understand the transition from the PbR Guidance to the NTD, we propose that the majority of content from the 2013/14 PbR Guidance publication (and other associated 2013/14 PbR documentation) will be migrated to an appropriate section within the consultation 'notice' and the final NTD. This will enable us to align the NTD with the legislation, while at the same time supporting continuity in the understanding and application of the payment system.

A mapping of all 2013/14 PbR documentation to the proposed NTD for 2014/15 can be found in Appendix D. We will update this mapping ahead of the statutory consultation following any feedback from stakeholders that we receive in response to this document.

Non-mandatory supporting guidance for the payment system has previously been set out alongside PbR rules within the PbR Guidance for 2013/14 and other associated PbR documents. While the Act allows Monitor to include supporting guidance within the NTD and provides that commissioners will have a statutory duty to have regard to such guidance if so

[8] Best practice tariffs are paid to providers in place of normal tariffs, if best practice guidelines for treatment are followed. Best practice is defined as care that is both clinically and cost effective, and is different for each procedure.

included, we believe that there are advantages for users of the NTD for supporting guidance documents to be placed outside of the formal NTD itself.

We believe that there may be two key advantages of placing guidance outside the structure of the NTD. First, it should help readers to distinguish between the mandatory requirements within the NTD and the non-mandatory guidance outside of the NTD. Second, placing non-statutory guidance outside of the NTD gives us flexibility to update guidance as required rather than be restricted to the NTD publication cycle (currently annual).

We want to ensure that the NTD is a stand-alone practical document. So, with the relevant guidance published outside the document, we will aim to ensure that the rules themselves are fully detailed and explained in the document itself, to minimise reliance on the external guidance documents.

DQ1. What changes could be made to the proposed structure of the NTD and supporting documentation to make the material more accessible and the document easier to use?

3 Our approach to the 2014/15 Tariff

This section sets out our proposed approach to setting the tariff in 2014/15, and the basis for the currencies and prices that it contains. The process for consultation and objection described in Section 2.3 is relevant to the proposed methods in Sections 3.1, 3.3, 3.5 and 3.6[9].

This section is structured as follows:

- in Section 3.1, we explain our principles and approach to setting prices for the 2014/15 tariff;
- in Section 3.2, we discuss our proposed changes to the services to be priced in the tariff (more detail on these changes is in Appendix C);
- in Section 3.3, we discuss the method for the new and updated prices that we have to determine in order to have a complete set of tariff prices (in 2013/14 prices) on which to base the 2014/15 tariff;
- in Section 3.4, we set out the new prices arising from the methods set out in Section 3.3;
- in Section 3.5, we discuss the specific methods for uplifting the tariff for 2014/15 to reflect inflation and other cost pressures on the NHS as a whole; and
- in Section 3.6, we discuss the method for determining the level of efficiency we expect providers to achieve in 2014/15.

3.1 Our principles and approach to setting prices

Monitor has a statutory duty to set tariff prices, which is to apply for 2014/15 and subsequent years. In this section, we discuss:

- our principles for setting prices; and
- our approach for 2014/15.

3.1.1 Our principles for setting prices

This is the first time that we have set tariff prices, so we have not previously established the principles that we should be guided by when undertaking our pricing function. The following list is a preliminary set of principles we propose to follow, which reflect the statutory framework. These principles may be revised in the light of stakeholder responses to this document.

We propose that prices should be set so as to:

- encourage the better serving of patient needs in both the short-term and long-term – Monitor's primary duty[10], which applies to its tariff functions, is to protect and promote the interests of patients, by promoting the provision of services which is economic, efficient and effective, and which maintains or improves the quality of services[11]. Our

[9] When we refer to method or methodology in this section, we mean the definition of 'method' for determining national prices as set out in section 118(3)(b) of the Health and Social Care Act 2012. The method is in Sections 3.1, 3.3, 3.5 and 3.6.
[10] See section 62(1) of the Act.
[11] In addition, Section 66(2)(a) and (e) of the Act requires Monitor to have regard to "*the desirability of securing continuous improvement in the quality of health care services provided for the purposes of the NHS and in the*

pricing decisions can help provide signals and incentives to enable delivery of unit cost reductions that, all else being equal, will allow better health care in the NHS given the fixed budget. But they must also be sustainable: if prices are reduced too much or too quickly, the disruption to providers could damage the long-term needs of patients; and

- reflect efficient costs – one function prices play in the NHS is to signal costs that are associated with the delivery of each given service, and in particular, those costs that would likely be incurred by an efficient operator in supplying health care services to the level of quality expected by commissioners. Cost reflectivity of prices is important as it can give providers an opportunity to recover their efficiently incurred costs (which will typically include provisions for the depreciation and financing of capital expenditure as well as for necessary operating expenditure). This can be particularly important in the context of longer term outcomes, as it can allow providers to expect to earn a reasonable return on their investments. Cost reflectivity is also important in terms of the signals that it sends commissioners when making decisions about which mix of services is likely to offer the highest value to patients. It can therefore promote more effective usage of available budgets[12.]

In addition to these principles and the statutory duties already mentioned, Monitor will also consider various other matters when setting prices and exercising its other tariff functions, in accordance with its general duties under the Act. In particular we will:

- consider how to exercise Monitor's tariff functions in a way which enables health services to be provided in an integrated way and prevents anti-competitive behaviour which is against the interests of patients (Section 62(3) & (4));
- act in a manner consistent with the performance of the Secretary of State's duty to promote a comprehensive health service, for example, in the objectives he sets in NHS England's annual mandate (Section 62(9));
- have regard to the need for commissioners to ensure access to services and that access is fair (Section 66(2)(b) and (c)); and
- have regard to the need to promote research by providers and the need for high standards in education and training of health professionals who provide NHS services (Section 66(2)(f) and (g)).

When seeking to set prices in line with our statutory duties and the principles described above, we will put particular emphasis on the importance of evidence-based assessments. We will place the most weight on reliable, independent, and objective evidence.

We are mindful of some important **trade-offs** when setting prices. One of those trade-offs is between efforts to improve the accuracy of prices and the complexity of the process that may be involved when calculating those prices. There are many factors that can influence the efficient cost of providing services to patients. These may be specific to the patient, to the provider, or to the context in which services are provided. Attempting to create a pricing system that reflects all of these factors could lead to a more accurate reimbursement of

---

efficiency of their provision" and "the desirability of persons who provide health care services for the purposes of the NHS co-operating with each other in order to improve the quality of [those services]".

[12] Section 66(2)(d) of the Act requires Monitor to have regard to "*the need for commissioners of health care services for the purposes of the NHS to make the best use of resources when doing so*".

costs, if sufficiently accurate cost data were available. However, such a system may turn out to be too complex, very costly, lacking transparency and therefore failing to give the right signals and incentives to providers and commissioners.

A further trade-off is that:

- all else being equal, lower prices allow commissioners to buy a higher volume of services, which will improve services to patients. Setting prices too high, therefore, would disadvantage patients, by reducing the volume of services that they receive within a given budget. Inefficiently-high prices may arguably also reduce the incentive for providers to find cost savings, which would detract from value for patients in the long run; but
- setting prices that are too low can be just as detrimental to patient interests, particularly in the long run:
    - commissioners may 'over-purchase' those services relative to others, because their perception of value for money will be distorted (ie they will perceive the resource costs of those services to be lower than they really are); and
    - providers may not be adequately compensated for the services they provide, potentially leading to withdrawal of services, compromise on service quality, and/or under-investment in the future delivery of high value services.

However, the relationship between cost and quality is complex: some providers have shown that they can achieve *both* higher quality and lower costs (compared to other providers, and looking at improvements over time). For example, reducing unnecessary complications that arise from patient services both improves quality and reduces costs.

A key challenge for price setting will be to determine the cost measures that should be used when setting prices. Previous tariffs have effectively been set at the level for a provider with the average measured level of costs. Our proposed approach to 2014/15 does not look to move away from this. However, in future, it may be more appropriate to set different types of cost benchmark, and the ways in which efficient levels of cost are assessed might differ across service groups or segments.

3.1.2 Our approach to setting prices in 2014/15

We propose to set a tariff in 2014/15 that places considerable weight on maintaining stability relative to the 2013/14 tariff. Two factors have influenced our approach:

- the NHS overall is going through extensive change already in this year of transition. Therefore we are seeking to provide additional certainty to the sector. We look to do this by keeping relative prices broadly stable and by publishing prices earlier in the year to help commissioners and providers to plan for 2014/15; and
- this is the first time that Monitor and NHS England have been responsible for the tariff, and this new arrangement inevitably introduces some risks (eg handover in systems, data and processes, etc.). We want to minimise these risks to ensure the transition is as smooth as possible, in the interests of all stakeholders, including, most importantly, patients.

While our overall approach to 2014/15 is to maintain a stable tariff to reduce uncertainty and risk in this year of transition, we need to ensure that the 2014/15 tariff is still clinically

relevant and sufficiently up-to-date. For this reason, we propose to make a number of additional changes which include introducing a limited number of new services with associated prices, and amending a small number of existing prices. These are set out in Sections 3.2 and 3.3.

Taking into account our desire for stability in the tariff, we propose to calculate prices for 2014/15 in the following way:

- using 2013/14 prices as the base (after introducing some minor updates to support clinical development); and
- adjusting those prices generally for cost pressures on the NHS as a whole, offset by our expectations for improved efficiency on the part of providers.

At the moment, we expect to apply this approach to determining prices for 2014/15 only. This approach is consistent with our duty (in Section 119 of the Act) to ensure that the prices for NHS health care services will result in a fair level of reimbursement for health care providers. As part of this duty, we should work to secure the standardisation throughout England of the way that health care services are specified, unless standardisation is likely to have a significant adverse impact on the provision of those services. The 2013/14 tariff has been designed to provide standardised services throughout England as much as possible, and the prices were set to ensure that an average provider could recover its costs. The application of cost uplifts and efficiency will ensure that these features remain in place in 2014/15, and so we are satisfied that this approach will give providers a fair level of reimbursement.

However, we are likely to propose a different method for 2015/16, based on updated cost data (which is likely to include reference costs data as well as potentially PLICS[13] data) instead of the previous year's prices, in order to enable us to send more appropriate price signals and incentives. We will continue to regard predictability and transparency as important elements of our regulatory role.

Consistent with the approach of keeping the tariff relatively stable, we intend to leave other features of the tariff unchanged, for example:

- prices for non-elective care that are calculated separately from the combined price which covers both elective care and day cases;
- separate prices for admitted patient care, outpatient attendances and procedures, and for Accident and Emergency;
- the extra per-day tariffs for stays beyond a certain set number of days for admitted patient care. The number of days is known as the "trimpoint" and varies by HRG and between non-elective and elective admitted patient care. We propose that the trimpoints for 2014/15 are also the same as in 2013/14;
- the short-stay emergency tariff, an adjustment for ensuring that short emergency stays (of less than two days) are appropriately reimbursed, where the average length of stay of the HRG is longer; and
- a series of Best Practice Tariffs.

[13] Patient Level Information and Costing Systems (PLICS) data will be collected by Monitor for the first time in the summer of 2013.

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 year's prices.

Do you agree with this rollover approach for the 2014/15 tariff (using 2013/14 prices as the basis for adjustment)? Please give your reasons.

3.2 Currency updates to support clinical development

As set out in Section 3.1, our proposed approach to the tariff for 2014/15 is to use the 2013/14 tariff prices as a base, but introduce (minor) updates where necessary to support clinical development. These updates fall into one of the following four categories:

- HRG design changes;
- new and amended Best Practice Tariffs;
- new mandatory prices for assessments of looked after children, made out of area; and
- a correction to the 2013/14 tariff.

In this section, we introduce each of these categories of updates. For each update, further details are provided in Appendix C.

3.2.1 HRG design changes

The 2014/15 tariff will have more than 2,500 prices[14]. These prices are largely organised according to Healthcare Resource Groups (HRGs), which represent clinically meaningful groupings of conditions or interventions that have, or should have, similar resource costs[15].

HRGs are the unit of purchase for tariff-based activity in the NHS[16]. In accordance with the Act, NHS England will decide:

- which health care services will be included in the tariff; and
- how these services will be grouped for pricing purposes (ie into HRGs).

We refer to the second step above as HRG 'design'. The list of proposed changes – which either introduce new HRGs or change HRGs or map specific procedures or diagnoses to different HRGs – is set out in Table 3-1 and Appendix C. Table 3-1 shows which of these affect prices, and which do not. Changes to specified high-cost drugs, devices and procedures (previously known as 'exclusions') are in Section 4.

As described in Appendix C, the latest update to the OPCS4 (Office of Population Censuses and Surveys 4) codes for operations, procedures, and interventions will be implemented from April 2014.

[14] Including all combinations of HRG, admission method, service and 'excess bed days'.
[15] More detail, and the current HRG design (in use for payments for 2013/14) can be found at http://www.hscic.gov.uk/hrg
[16] Inpatient, A&E and outpatient procedures.

3.2.2 Changes in Best Practice Tariffs

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

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

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

The service areas covered by BPTs are all selected using the following criteria:

- high impact (ie high volumes, significant variation in practice, or significant impact on outcomes);
- a strong evidence base for what constitutes best practice; and
- clinical consensus on the characteristics of best practice.

The first BPTs were introduced in 2010/11 following Lord Darzi's review of the NHS in 2008[17]. In 2013/14, 17 mandatory best practice tariffs were included in the DH PbR guidance.

For 2014/15, we are proposing to introduce one new BPT and make amendments to two existing BPTs**.** The updates are summarised in Table 3-1 and detailed in Appendix C. There are no proposed changes to the design of any of the other existing BPTs for 2014/15. Further information on the existing BPT areas, including operational level guidance, policy information and the price-setting approach can be found in Section 8 of the 2013/14 PbR Guidance document[18].

3.2.3 New mandatory prices

For 2014/15, we propose to introduce a new mandatory price for out of area health assessments for looked-after children.

3.2.4 Correction to 2013/14 tariff

For 2014/15, we propose to amend the elective care/day case price of one HRG (RC31Z) to correct for an oversight in the 2013/14 tariff.

[17] "High Quality Care For All", presented to Parliament in June 2008.
[18] Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/141388/PbR-Guidance-2013-14.pdf.pdf.

3.2.5 Summary of proposed currency updates

The proposed currency updates for the 2014/15 tariff are summarised in Table 3-1 below, which also indicates whether the change is reflected in either the Engagement Grouper (that we are releasing alongside this Tariff Engagement Document) or in the Autumn Consultation Grouper[19].

Table 3-1: Proposed currency design changes for 2014/15 tariff

Description of change	New/revised price for 2014/15?	Which Grouper will include this
New HRGs		
Kidney and ureter: reflect relative costs of laparoscopic and open procedures	Yes	June
Complex therapeutic endoscopy: correct for under-reimbursement	Yes	June
Complex bronchoscopy: correct for under-reimbursement	Yes	June
Acute kidney injury: identify dialysis procedures	No	June
HRG design changes		
STARR[20]: adjustment for under-reimbursement	No	June
Fractional flow reserve (FFR): correct for under-reimbursement	No	June
Orthopaedics: better reflect the costs of treatment for physical abuse	No	June
Spinal surgery[21]: correct for under-reimbursement	No	autumn
Electroencephalograph telemetry: correct for under-reimbursement	No	autumn
Intravenous induction of labour: discourage incorrect coding	No	June
General coding: encourage coding of ‘other’ and ‘unspecified’ procedures correct chapters	No	June
New or amended best practice tariffs		
New best practice tariff: Primary hip and knee replacements	Yes	n/a
Amended best practice tariff: Paediatric diabetes	Yes	n/a
Amended best practice tariff: Major Trauma	No	n/a
New mandatory prices		
Health assessments for looked after children out of area	Yes	n/a
Corrected prices from 2013/14 tariff		
RC31Z (Interventional Radiology Procedures - Hepatobiliary – Major)	Yes	n/a

[19] The Grouper is software produced by the Health & Social Care Information Centre to map activity data (coded as operation & procedure and/or diagnosis codes) to HRGs. The grouper software does not apply exclusions or tariff prices. For more details and/or to download the current Grouper, please see: http://www.hscic.gov.uk/casemix/downloads.

[20] Stapled transanal rectal resection for obstructed defecation syndrome

[21] Specifically: Spinal surgery for posterior instrumented spinal instrumentations and decompressions for tumour and deformity

In the following section (Section 3.3) we set out our proposed methods for determining national prices for the updates which we consider require pricing decisions for the 2014/15 tariff.

3.3 Method for determining prices for new or changed currencies

Section 3.2 set out the changes to currencies that are to be priced. For some of the updates, we propose to introduce or update certain tariff prices. In addition, there is one price change that is a correction of a price published for 2013/14. This section sets out the method for determining the prices for any such new or updated currencies.

In total, 24 prices change from the 2013/14 tariff as a result of the currency design changes in Section 3.2. Around 99 per cent of relative prices remain unchanged. These changed prices, along with all of the unchanged prices from 2013/14, form the base for the 2014/15 tariff. The prices are then subject to adjustment to reflect inflation, other cost pressures and efficiency: the method for making those adjustments is set out in Sections 3.5 and 3.6.

3.3.1 New HRGs for laparoscopic and open kidney and ureter procedures

Laparoscopic operations on the kidney and ureter are a single HRG in 2013/14. The HRG change permits more complex laparoscopic operations, such as nephrectomy (kidney removal), to be priced more appropriately. The new HRG design also takes better account of the presence or absence of complications or co-morbidities. As a result, six HRGs are deleted and eight new HRGs are created, which need to be priced. More detail on these proposed changes can be found in Appendix C.

The method used to calculate the prices for these eight new HRGs is set out below. The method has two key features:

- the relative prices of the eight HRGs reflect the latest data on their relative cost; and
- total spend is unaffected by the new HRG design.

To do this, **first** we calculated how much the activities in the new HRGs cost the NHS in total – and the level of activity in these HRGs. We are setting national prices that apply to a typical length of stay. (These prices will be supplemented by "excess bed day" payments for patients who stay significantly longer than average – and an uplift called the Market Forces Factor (MFF) to take account of unavoidable location-specific cost differences of providing health care.) We therefore need to calculate the "inlier"[22] spend, and how that maps to the eight new HRGs:

- Activity for each HRG was identified using the latest appropriate HES[23] data. This covers 2011-12. In specific terms, we counted spells within one of the new HRGs using the 2011-12 "reference cost grouper"[24].
- The same activity can also be split between the old HRGs, used in the 2013/14 tariff.

[22] "Inlier" spend covers all admitted patient care activity where the length of stay of the patient does not trigger payment of extra money. It therefore excludes "excess bed day" payments.
[23] Hospital Episode Statistics, as submitted by NHS organisations through their Patient Administration Systems (PAS).
[24] The grouper is the software, produced by the Health & Social Care Information Centre, which groups diagnosis and procedure information from NHS organisations into the appropriate currency (HRG) for costing and payment.

- These old HRGs each had a tariff in 2013/14. We calculated the total "inlier spend" by multiplying the activity by the standard ("inlier") 2013/14 tariff (ie not including excess bed day payments or other pricing adjustments). There were different tariffs for different HRG and for different admission methods (non-elective and day case / elective care), so this calculation was done for each tariff price separately.

The total affected activity is around 16,000 spells. The quantum of spend is around £73m, excluding MFF.

Second, we calculated the relative costs of each of the new HRGs. This showed which HRGs were more expensive and which were relatively cheaper. There are different costs – and different prices – for non-elective care and for elective care/day cases.

Calculating the relative costs is based on inlier costs reported in the 2011/12 reference cost collection[25], with MFF removed.

The relative costs are shown as a multiple of the lowest cost HRG[26].

A logic check was then carried out on the relative costs to ensure that the reported costs for 'with complications and comorbidities' were not less than the costs for 'without complications and comorbidities'. Reference costs were consistent with this for most HRGs, but not for two HRGs (LB62A and LB62B, for non-elective care only). As a result, a non-elective weighted average unit cost was produced across HRGs LB62A and LB62B, which was used in the subsequent calculations.

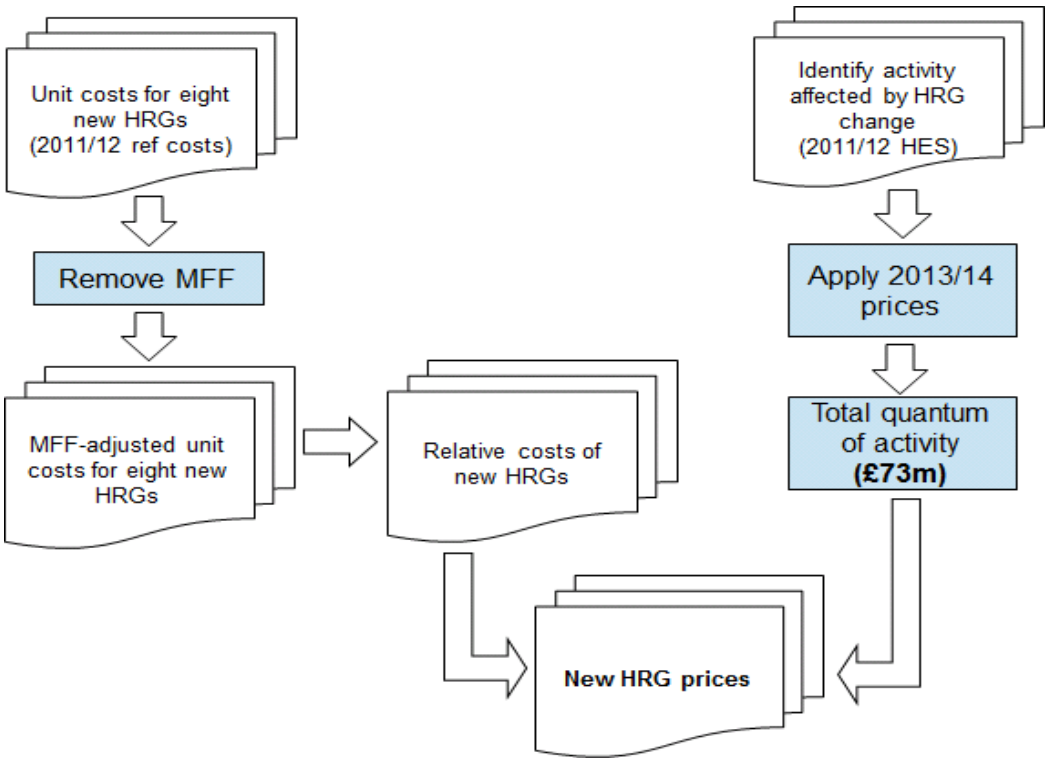
Third, we determined the tariff prices for the new and affected HRGs, in 2013/14 prices. This used the relative costs, activity data and total spend (calculated above).

A final adjustment was made to ensure that the total spend (for a given total level of activity) for the new HRGs is the same as if the HRG design had not been introduced. This takes into account excess bed days as well as inlier spend. As a result of this final step, all tariffs for the eight HRGs were increased by 2.5%.

The steps described above are illustrated in Figure 3-1.

[25] Reference costs are the average unit cost to the NHS of providing a defined service in a given financial year, as submitted by NHS organisations annually. The relative costs are calculated using 2011/12 reference cost data, as reference cost data for 2010/11 did not contain these HRGs.
[26] The choice of this as the base to represent the relative cost of the HRGs does not affect the final prices.

Figure 3-1: Illustration of approach to setting new HRG prices in laparoscopic procedures



The tables below set out the new HRG codes and their related cost relativities and calculated tariff prices.

The relative price is based on the relative inlier cost in 2011/12 reference costs. A relative price of 1.0 is the lowest-cost HRG (LB61B). The activity levels are from the latest (2011/12) HES data.

Table 3-2: Day cases / elective care: Relative costs and prices for the eight new HRGs

HRG	Relativity	Activity (spells)
LB60A - Complex Open or Laparoscopic, Kidney or Ureter Procedures, with Major CC	2.0	519
LB60B - Complex Open or Laparoscopic, Kidney or Ureter Procedures, without Major CC	1.2	1,953
LB61A - Major Open Kidney or Ureter Procedures, 19 years and over with Major CC	1.5	634
LB61B - Major Open Kidney or Ureter Procedures, 19 years and over without Major CC	1.0	4,283
LB62A - Major Laparoscopic Kidney or Ureter Procedures, 19 years and over with CC	1.2	2,125
LB62B - Major Laparoscopic Kidney or Ureter Procedures, 19 years and over without CC	1.1	1,685
LB63A - Major Open or Laparoscopic, Kidney or Ureter Procedures, 18 years and under with CC	1.4	206
LB63B - Major Open or Laparoscopic, Kidney or Ureter Procedures, 18 years and under without CC	1.0	673

Table 3-3: Non-elective care: Relative costs and prices for the eight new HRGs

HRG	Relativity	Activity (spells)
LB60A - Complex Open or Laparoscopic, Kidney or Ureter Procedures, with Major CC	2.0	1,684
LB60B - Complex Open or Laparoscopic, Kidney or Ureter Procedures, without Major CC	1.4	947
LB61A - Major Open Kidney or Ureter Procedures, 19 years and over with Major CC	1.5	590
LB61B - Major Open Kidney or Ureter Procedures, 19 years and over without Major CC	1.0	701
LB62A - Major Laparoscopic Kidney or Ureter Procedures, 19 years and over with CC	1.6*	47
LB62B - Major Laparoscopic Kidney or Ureter Procedures, 19 years and over without CC	1.6*	20
LB63A - Major Open or Laparoscopic, Kidney or Ureter Procedures, 18 years and under with CC	2.3	55
LB63B - Major Open or Laparoscopic, Kidney or Ureter Procedures, 18 years and under without CC	1.4	24

*Note: *the relativities for these HRGs are not consistent with Reference Costs, as a weighted tariff across LB62A and LB62B has been set.*

The proposed tariff prices (in 2013/14 prices) are set out in Section 3.6.

3.3.2 New HRGs for complex therapeutic endoscopy and complex bronchoscopy

We propose to publish a price for these new HRGs as part of the formal consultation process in autumn. The prices will be based on both reference costs for 2012/13 (as the 2011/12 reference cost collection did not collect these cost data) and will also take into account other expert advice on the appropriate cost of these procedures. The cost of all relevant procedures, devices and consumables will be included in this price – see Section 4.3.1 for further details on changes to specified high cost drugs, devices and procedures (previously referred to as "exclusions" to the tariff).

3.3.3 New BPT for Primary Hip and Knee Replacements

The proposed standard best practice tariff for primary hip and knee replacements will be set at the same level as for 2013/14 (before the cost uplift and efficiency factor adjustments).

Those providers who do not meet the criteria set out in Appendix C will receive a tariff 10% below the BPT. More detail is provided in Appendix C. This adjustment balances a need to ensure that the amount received for meeting the BPT criteria is sufficient to incentivise an appropriate response by providers while ensuring that the financial risk is not too great. No other prices are affected by this change.

3.3.4 Amended BPT for Paediatric Diabetes

A proposed revised BPT has been set based on data provided from 31 best practice sites, on the number of unavoidable non-elective admissions for diabetes that they had for the children on their registered caseload. The data were used to calculate an average annual admission rate for this cohort of children (14%). There will also be some elective admissions that are part of good clinical management and also therefore unavoidable. To reflect the potential unavoidable elective admissions, we propose to base the tariff price on an assumed admission rate of 20%, following discussions with stakeholders.

To reimburse providers for this expected admission rate, we propose that 20% of the weighted average cost of admission of the two relevant HRGs (PA67Z and PA68Z) is added to the 2013/14 best practice tariff price of £2,764, making a total of £2,988 (in 2013/14 prices).

3.3.5 Amended BPT for Major Trauma

Some of the criteria for the major trauma best practice tariff are changing, but we do not propose making any adjustment to the price as a result.

3.3.6 Mandatory price for out of area looked after children health assessments

We propose to base the new mandatory prices for out of area looked after children health assessments on the (non-mandatory) prices that were in the 2013/14 tariff[27].

[27] When children are placed in care by local authorities, their responsible health commissioner has a statutory responsibility to commission an initial health assessment and review it either every six months or every year.

3.3.7 Correction to price for RC31Z (Interventional Radiology Procedures - Hepatobiliary – Major)

We propose that the price for elective activity in RC 31Z (Interventional Radiology (IR) Procedures - Hepatobiliary – Major) will be amended to be the same as the price for non-elective activity. This amendment corrects an oversight in the 2013/14 tariff.

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? Please give reasons.

3.4 Prices

The proposed prices for new or changed HRGs/Best Practice Tariffs, developed using the methodology in Section 3.3, are as follows. A spreadsheet setting out these prices is also available at www.monitor.gov.uk/pricing

All these are in 2013/14 prices, so as to be comparable to the 2013/14 tariff. The impact of the efficiency, inflation and other cost pressures will be incorporated to produce 2014/15 prices for the autumn consultation.

The 2013/14 tariff can be found at: https://www.gov.uk/government/publications/payment-by-results-pbr-operational-guidance-and-tariffs

3.4.1 New HRGs for laparoscopic/open kidney and ureter procedures

Proposed tariffs for the eight new HRGs are shown below.

Table 3-4: Tariffs for laparoscopic/open kidney and ureter procedures

Code	Tariff (£) - Day case/elective	Tariff (£) – Non-elective
LB60A	7,670	7,098
LB60B	4,427	4,913
LB61A	5,752	5,089
LB61B	3,743	3,478
LB62A	4,421	5,538
LB62B	4,032	5,538
LB63A	5,127	7,842
LB63B	3,897	4,978

The above prices apply in respect of patients with a typical length of stay. There is additional reimbursement ("excess bed day" payments) in respect of patients who remain in hospital beyond a particular threshold number of days. The threshold is called the "trimpoint". Beyond this threshold, the excess bed day payment is £414 per day for children-

specific HRGs (LB63A and LB63B) and £205 per day for all other HRGs: the same as the other HRGs in chapter L (Urinary Tract and Male Reproductive System).

Table 3-5: Trimpoints for laparoscopic/open kidney and ureter procedures

Code	Trimpoint (days) - Elective care	Trimpoint (days) – Non-elective
LB60A	43	61
LB60B	16	33
LB61A	26	57
LB61B	15	26
LB62A	11	40
LB62B	7	40
LB63A	12	54
LB63B	5	16

3.4.2 New HRGs for complex therapeutic endoscopy and complex bronchoscopy

We propose to publish new prices for both these HRGs in the autumn consultation.

3.4.3 New BPT for Primary Hip and Knee replacements

The BPT prices are unchanged from 2013/14 levels. Those providers not meeting best practice will receive a lower 'non-best practice tariff'.

Table 3-6: Tariffs for Primary Hip and Knee replacements

	HRG description	Best practice tariff (£)	Non-best practice tariff (£)
HB12B	Major Hip Procedures for non Trauma Category 1 with CC	6,032	5,429
HB12C	Major Hip Procedures for non Trauma Category 1 without CC	5,280	4,752
HB21B	Major Knee Procedures for non Trauma Category 2 with CC	6,405	5,764
HB21C	Major Knee Procedures for non Trauma Category 2 without CC	5,707	5,136

3.4.4 Amended BPT for Paediatric Diabetes

The proposed price for these patients for the 2014/15 tariff is £2,988 (in 2013/14 prices).

3.4.5 Amended BPT for Major Trauma

The criteria for being paid this BPT have changed – but the price has not.

3.4.6 New mandatory prices for looked after children health assessments

The tariffs for looked after children health assessments are unchanged (in 2013/14 prices). These are shown below. The proposed change is that these would be mandatory prices for looked after children placed out of area.

Table 3-7: Prices for looked after children health assessments

Assessment type	Tariff (£)
in area initial health assessment	419 (non-mandatory)
In area review health assessment	215 (non-mandatory)
out-of-area initial health assessment	450 (mandatory)
out-of-area review health assessment	262 (mandatory)

3.4.7 RC31Z (correction of price from 2013/14 for Interventional Radiology Procedures – Hepatobiliary Major)

The proposed price for this procedure in elective care for the 2014/15 tariff is £4,638 (in 2013/14 prices). This is the same as the current price for the non-elective tariff.

3.5 Methodology for determining tariff uplifts

As described in Section 3.1, we plan to calculate prices for 2014/15, based on the corresponding prices for services in 2013/14 (with 24 updated prices to reflect the currency design changes), with adjustments for:

- inflation and other cost pressures on the NHS as a whole, offset by; and
- our expectations for improved efficiency on the part of providers.

In this sub-section we discuss inflation and other cost pressures on the NHS.

Each year, providers will typically tend to find that their input unit costs have increased, due to factors beyond their control. In most situations, when all providers of a product or service experience an increase in their input costs, the price that they charge for the product or service also increases. For this reason, it seems appropriate to reflect some anticipated cost input changes in regulated prices, and that is the approach we propose to take with the tariff for 2014/15. In addition, both over time and also as input costs rise, providers should find ways to reduce their costs (for a given level of output and quality), which will flow through to lower prices: this is captured by the 'efficiency factor', which is discussed in Section 3.6.

We expect that uplifting prices for expected cost inflation will be an ongoing feature of NHS price setting, regardless of the specific methods used to set prices in the future. The inflation measures that we use might change over time, but the tariff is likely to include some form of annual adjustment for the expected increase (or decrease) in levels of input costs.

In other regulated sectors, cost uplift is sometimes covered by a single factor; usually the retail price index (RPI), but we consider a more tailored approach is appropriate for the NHS.

For several of the major cost categories for providers, we have more precise data on cost changes than a general inflation index and will therefore reflect cost movements more accurately[28].

We will consider cost uplifts in 2014/15 across four main categories:

1. inflation – which is split into:

    (a) pay;
    (b) drug costs; and
    (c) non-pay, non-drug costs (such as clinical equipment).

2. changes in Clinical Negligence Scheme for Trusts (CNST) costs;

3. revenue cost consequences of capital (ie depreciation and PFI payments). Depreciation and PFI payments, made by providers, are included in the tariff prices for 2013/14. The estimate of how these have changed for 2014/15 is included in the methodology; and

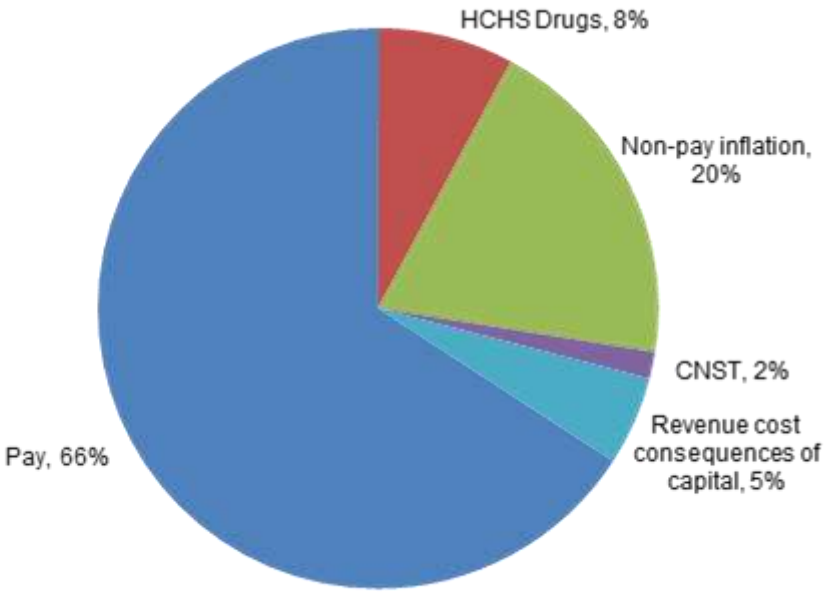
4. any additional costs as a result of service-wide requirements (referred to as "service development"). An example for 2013/14 was clinical re-validation.

For each factor, we are looking to reflect the additional cost pressures in 2014/15 for an average provider in the tariff. We will collect data about the projected growth in costs. To ensure we have the right total uplift, we need to apply the projected growth in costs of each category to the relevant cost base of that category.

Figure 3-2 shows the proportion of Hospital and Community Health Services (HCHS) revenue costs that is covered by each cost category. This is the baseline that we are using for 2014/15: it is based on projected data from DH about DH's 2013/14 HCHS expenditure.

[28] Note that in each case we are adjusting for expected inflation (from 2013/14 to 2014/15) rather than current inflation levels.

Figure 3-2: Breakdown of HCHS costs



Source: DH, with Monitor calculations. Totals may not add up to 100% because of rounding

Table 3-8 shows the figures for pay growth and non-pay, non-drugs inflation which DH incorporated into their last three tariffs (ie 2011/12 to 2013/14) which were national averages, based on the best available estimates when the tariff was set. The figures are expressed as a contribution of the inflation of each cost input to the aggregate tariff uplift[29].

Table 3-8: Contributions to aggregate tariff uplift

Increase in pay and prices	**2011/12**	**2012/13**	**2013/14**
Pay	1.4%	0.9%	1.5%
HCHS Drugs	0.4%	0.4%	0.5%
Non-pay, non-drugs inflation	0.6%	0.7%	0.5%
CNST (not allocated to individual HRG sub-chapters)[30]	0.0%	0.0%	0.0%
Revenue cost consequences of capital	0.2%	0.2%	0.2%
Service development	-	-	0.1%
Total*	**2.5%**	**2.2%**	**2.7%**

[29] These contributions are calculated by multiplying the inflation of each input by its share of the total cost base.
[30] Most CNST is allocated to HRGs, as explained in Section 3.5.2 below: the CNST shown is the residual amount that is not allocated to HRGs and forms part of tariff uplift.

*Source: DH. * Totals may not add up because of rounding. Figures in the CNST row are less than 0.05% in each year; the majority of the CNST element of the price is included at HRG sub-chapter level: we expect to include those CNST figures in the autumn consultation.*

With respect to the 2014/15 tariff uplift:

- We expect that pay settlements and non-pay, non-drugs inflation will contribute 1.1% to the uplift to the tariff if current figures remain unchanged.
- The other elements of the tariff uplift, that we have not been able to quantify at this stage, contributed 1.9%, 1.4% and 1.7% in 2011/12, 2012/13 and 2013/14 respectively. Figures for those same elements for 2014/15 will not be available until the autumn consultation or later.

In the rest of Section 3.5, we describe in more detail the methodology and data for each of the uplift factors listed above. We also discuss some timing considerations – some of the data we propose to use will not be available in time for our autumn consultation, so we need to manage the inclusion of these data in the final tariff carefully, and to make our process clear for stakeholders.

3.5.1 Inflation

This subsection sets out the data that we propose to use for each of the three inflation components, namely:

- pay;
- HCHS drugs; and
- non-pay, non -drugs inflation.

Pay

The DH maintains very detailed records of labour costs in the NHS, and we propose to use its data to set the tariff in 2014/15. Labour costs are a major component of total service costs in the NHS (see Figure 3-2), and it is important that we track these costs as accurately as possible when setting the tariff.

Pay-related inflation is split into two categories:

- pay settlements, which refers to the increase in the unit cost of labour reflected in pay awards for the NHS; and
- pay drift, which refers to changes in the average unit cost of labour due to changes in the overall staff mix (eg balance of senior vs. junior staff; specialist vs. non-specialist). This also includes changes to the amount of overtime and other allowances being paid as well as any changes to the cost for pension provision or any other staff-related costs. The increase in employers' National Insurance in 2011/12 is included in this category.

The figures for pay in Table 3-8 include both pay settlements and pay drift.

The final data for pay settlements for 2014/15 will arrive after the NHS Pay Review Bodies have reported and the Government has announced its response. This is due to happen late in 2013, after the autumn statutory consultation. We propose to use the final pay settlements figure in the final tariff for 2014/15. For the autumn consultation, we intend to use the latest

announced Government figure for 2014/15. The Government's pay policy for 2014/15 was set in the 2011 Treasury Autumn Statement[31]: "*The Government will ... set public sector pay awards at an average of one per cent for each of the two years after the current pay freeze comes to an end*." For the NHS, the two years covered by this statement are 2013/14 and 2014/15.

Pay drift is based on data collected and analysed by the DH. We plan to incorporate, in the autumn statutory consultation, DH's estimate of pay drift informed by labour cost trends in recent years, as well as DH's expected changes for 2014/15. The data relate to:

- grade drift, when employees are on average higher up a pay scale or grade over time, and where a bigger proportion of a group of employees in the same grade are at or nearer the top end of the scale, and
- growth in overtime, allowances and/or London weighting.

HCHS Drugs

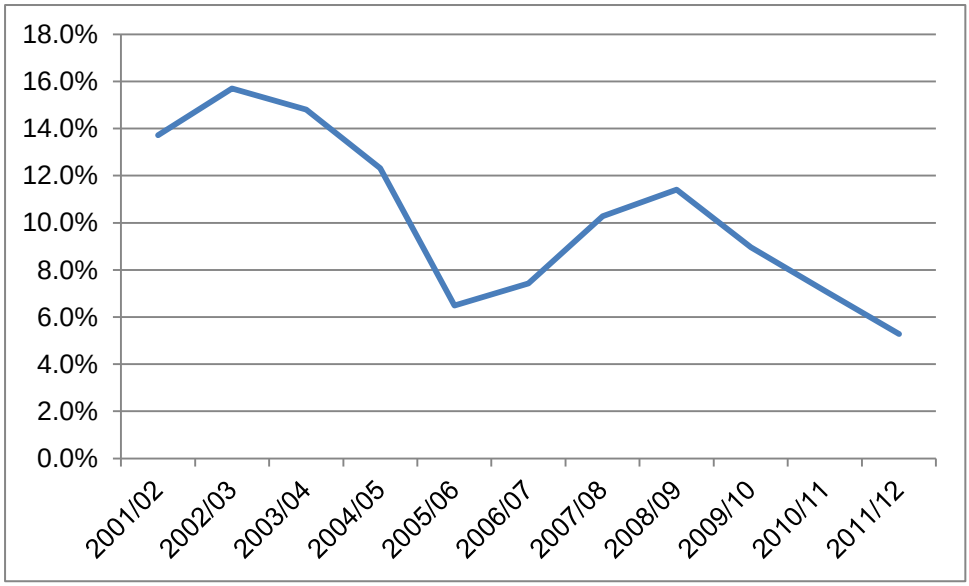
Drugs form a much smaller component of the NHS cost base than labour, but these costs have tended to grow much faster than labour costs.

We propose to include two data sources to inform the estimate of growth in drugs costs in the NHS in 2014/15, and we propose to use these data for cost uplifts in the 2014/15 tariff.

The first data source will be a projection from DH based on the long-term trend for the drug cost growth. We intend to include this in the autumn statutory consultation.

Figure 3-3 shows the increase in HCHS drugs spend from 2001/02 up to 2011/12.

Figure 3-3 - Historic HCHS drugs spend increases



Source: DH

[31] https://www.gov.uk/government/news/autumn-statement-2011--3

This year, the drugs costs projection is more complicated, because there are ongoing discussions as part of the review of the Pharmaceutical Price Regulation Scheme (PPRS[32]). When the current discussions are concluded, we will reflect their impact, using an estimate from DH of the effect on the costs to providers of secondary care drugs. This is the second data source for the drugs element of the tariff. We will include this second element before the final tariff is published, but the estimate may not be available before the autumn statutory consultation.

Non-pay, non-drugs inflation

The final inflation category aims to cover provider costs that are not related to labour, drugs or capital charges. This cost category includes general operational costs such as:

- medical, surgical and laboratory equipment;
- laundry and other cleaning; and
- fuel.

This cost category has a range of loosely related components. We consider that the Health Services Cost Index (HSCI)[33] is a reasonable proxy for these costs.

However, we need a forecast of non-pay, non-drugs inflation for 2014/15 in order to calculate the tariff, and the DH does not make forecasts of the HSCI.

We therefore propose, at least for this year, to continue the DH's approach of using the forecast of the GDP deflator estimated by the Office of Budget Responsibility (OBR) as the basis for the cost uplift calculations for this element of the tariff. The GDP deflator has the added benefit from a regulatory point of view that it is a widely recognised measure of inflation. The latest OBR forecast for the relevant period is 1.9%[34]. We expect to use the latest available published OBR forecast for the autumn statutory consultation. The OBR usually updates this forecast at the same time as the Chancellor's autumn Statement, and we would intend to reflect this forecast in the final tariff, consistent with our aim of using the latest evidence available when we publish the tariff.

3.5.2 Clinical Negligence Scheme for Trusts (CNST)

CNST is an indemnity scheme for clinical negligence claims. Providers make a contribution to the scheme to cover the (legal and compensation) costs of clinical negligence[35]. The NHS Litigation Authority (NHSLA) administers the scheme and sets the contribution that each provider must make to ensure that the scheme is fully funded each year.

We propose that the tariff continues to allow for the recovery of average CNST costs (ie average providers' contributions to the scheme). They are part of the cost base for all providers, and we consider that operators should be able to recover a fair share of these costs from tariff revenue.

[32] The PPRS is a voluntary scheme agreed between the DH and the branded pharmaceutical industry represented by the Association of the British Pharmaceutical Industry (ABPI) under section 262 of the National Health Service Act 2006.
[33] The HSCI measures the price change for 41 goods and services purchased by the NHS. See http://www.doh.gov.uk/doh/finman.nsf/af3d43e36a4c8f8500256722005b77f8/c2a9406dd513ef7d00256a6a004bf1ac?OpenDocument.
[34] Web link: http://www.hm-treasury.gov.uk/data_gdp_fig.htm
[35] Note that commissioners and NHS England are also members of the CNST scheme.

We also propose that the uplift of tariff prices for CNST should continue to differentiate between the mix of services from each provider[36]. Clinical negligence claims and payments are more prevalent in some types of health care than others[37]. We propose to continue to allocate total CNST costs to tariff sub-chapters[38] in proportion with the level of the clinical negligence payments made by the NHSLA in each area. Each HRG would then receive an uplift based on the change in CNST cost per unit of activity in that sub-chapter. There has also been a (small) proportion of activity that could not be allocated to sub-chapters - and, as before, the residual CNST that cannot be allocated to sub-chapters would be part of the general tariff uplift.

We note that the NHSLA has changed the way it sets contributions to the scheme, with much greater recognition of "claims history" from 2013/14 onwards. This change is likely to make some providers better off and some providers worse off, depending on whether their claims history is better or worse than the average.

Our approach is to reflect the cost changes for CNST by sub-chapter but not by individual provider. Any change introduced by NHSLA to tailor better contributions to the claims history or risk of the provider does not affect our approach to the CNST cost uplift, because CNST cost recovery in the tariff does not need to match individual provider contributions. The average cost of CNST by sub-chapter is largely external to the provider. However, individual providers can influence their own claims and we do not wish to alter the incentives that NHSLA create for providers to reduce their own clinical negligence costs as this would not be in patient interests.

3.5.3 Revenue cost consequences of capital (ie depreciation and PFI payments)

Changes to depreciation and PFI payments are equivalent to changes in operating costs for providers, so we propose to include them as one of the cost uplift components for the tariff. Movement in these costs will contribute to the funding required from one year to the next for the providers.

The 2013/14 tariff prices were based on 2010/11 reference costs. Reference costs include the costs of depreciation and unitary PFI payments. PFI schemes brought online since 2010/11 needed to be captured in the 2013/14 tariff prices. In calculating 2013/14 tariff prices, DH took into account estimates of changes in depreciation and PFI payments between 2010/11 and 2013/14. We propose to follow the same practice for 2014/15.

The DH tracks capital charges and PFI payments for providers, and will supply the data that we require for tariff purposes. The estimate for depreciation will be based on:

- the trend of provider net book value;
- plus the likely future capital investment;
- less previous depreciation and impairments.

[36] This would be consistent with Monitor and NHS England's duty under section 119(1) of the 2006 to have regard to differences between providers with respect to costs and the range of health care services they provide.
[37] For example, maternity care has a relatively high propensity to result in claims, and the resulting settlements can be higher as they reflect conditions that need service over a lifetime.
[38] Sub-chapters are larger groupings of HRGs (for example, sub-chapter AA refers to Nervous System Procedures and Disorders and sub-chapter AB refers to Pain Management).

For PFI payments (which are significantly smaller than depreciation), we propose to use DH estimates of the year on year change in unitary PFI payments as a result of new PFI schemes becoming operational.

These figures are due to be incorporated in our calculations for the autumn statutory consultation.

3.5.4 Service development

"Service development" reflects the additional costs to providers of major initiatives that are mandated by the DH. For example, in 2013/14, an additional £75m was included in the tariff, mainly to take account of the costs on the HCHS sector of clinical revalidation. This had the impact of adding 0.1% to the tariff uplift.

We propose to use NHS England's estimate of service development, which will be based on developments required under NHS England's Mandate. We propose adjusting the 2014/15 tariff to reflect any new initiatives required under the Mandate and for which there is reliable evidence that provider costs will increase as a result. This is due to be available in time for the autumn statutory consultation.

3.5.5 Timing of data inputs to reflect inflation and other cost pressures

We are mindful that there is a need to publish the new NTD to the health sector with sufficient time to enable planning for the coming year. This includes publishing the tariff in time to inform the annual negotiations between commissioners and providers, which normally take place mostly in the first quarter of the calendar year. However, information affecting the NTD continues to be published at various times of the year. The rest of this sub-section sets out how we plan to balance the competing objectives of:

- using the latest available information;
- providing certainty, as far as possible; and
- enabling the health sector to plan by publishing the tariff in a timely way.
- We will publish a notice for statutory consultation in the autumn. This will include:
- the uplift to take account of inflation and other cost pressures;
- the efficiency factor we intend to use;
- the resulting prices; and
- the method used to calculate the uplift, efficiency factor and the resulting prices.

However, not all the data that we propose to use to estimate inflation and other cost pressures will be available by the autumn. Where we do not have the final input data before statutory consultation, we will:

- set out clearly the data that will be used to calculate cost uplifts in the tariff – and what assumption we have made in calculating the prices for statutory consultation;
- identify the source for the data;
- explain how the data will be used in price calculations;
- describe the impact of a change in the data on the average tariff price; and
- include the date by which we expect to collect and include a final input for the tariff prices.

The data inputs which we expect to have to update after the autumn consultation are:

- **Pay settlements.** Currently the assumption is 1% consistent with the Treasury's 2011 autumn Statement. If there is an update to be made after the NHS Pay Review Bodies report, that would be incorporated in the final tariff.
- **Drug costs.** The autumn consultation on the National Tariff Document will include an estimate for the price uplift associated with drugs cost inflation, based on the long-run trend. The impact of the review of the PPRS is expected to be ready for December and included in the final tariff, but is unlikely to be available for the consultation.
- **Non-pay, non-drugs inflation.** We intend to include the latest available OBR forecast of the GDP deflator in the autumn consultation. In late 2013 (after the autumn consultation), there will be an update on inflation in the Chancellor's autumn Statement which we propose to apply in the National Tariff.

Table 3-9 below summarises the availability of data and approaches for the autumn consultation.

Table 3-9: Data sources for uplift due to inflation and other cost pressures

Item	Is data expected to become available after the start of the autumn consultation? If so, changes to be made for final tariff.	Implications for autumn consultation
Pay settlements	Yes – Pay Review bodies report in Nov/December Incorporate when available	Use 1% for autumn consultation
Pay drift	No	Include in autumn consultation
Drugs inflation	Partly - PPRS negotiation expected to conclude in November/December Adjust long-run trend estimate to reflect PPRS outcome [39]	Include long-run trend estimate in autumn consultation Adjust after PPRS negotiation
Non-pay, non-drugs inflation	Yes – updated forecast available in Nov/Dec after Chancellor's autumn Statement Update to reflect this forecast	Use latest available forecast for autumn consultation
Revenue consequences of capital	No	Include in autumn consultation
Service development	No	Include in autumn consultation
CNST	No	Include in autumn consultation – mostly applied at HRG sub-chapter level, but with a smaller element that affects the whole tariff

[39] Pharmaceutical Price Regulation Scheme – See https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/126922/Joint-DH-ABPI-statement-on-arrangements-for-pricing-of-branded-medicines-from-2014.pdf.pdf

Q2. We are proposing to calculate the cost uplift to the 13/14 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?

Please give your reasons for these answers.

3.6 Methodology for determining the efficiency factor

As described in Section 3.1, we propose to calculate prices for 2014/15 based on the corresponding prices for services in 2013/14 with adjustments for inflation and other cost pressures on the NHS as a whole, offset by our expectations for improved efficiency on the part of providers.

In this sub-section we discuss our expectations for improved efficiency on the part of providers.

Typically, providers should make ongoing improvements to the way they provide services, by more effectively organising their productive resources and controlling their costs. In most sectors of the economy, competitive pressure forces managers to make these improvements.

Regulated prices, such as the tariff, try to mimic this competitive pressure. This means that, excluding the inflationary effect of changes in input costs, prices for NHS services should be a little bit lower each year.

We refer to this downward adjustment in prices as the 'efficiency factor', or simply 'efficiency'.

We propose that the efficiency factor applies both to tariff prices and for other services covered by the *National Tariff Document*. In our guidance for prices negotiated locally, we will expect commissioners and providers to start from the same efficiency assumption as is used for tariff prices.

3.6.1 Our process for setting the efficiency factor

There are two ways we can consider this factor.

The first approach, which we would prefer if adequate data were available, is to estimate directly the efficiency gains that *providers* can make and that would be reflected in a reduction in providers' unit costs.

The second approach, if necessary, is to start with estimates of the efficiency gains that the *sector as a whole* might reasonably be expected to achieve, and to derive from them the share of those gains that should be reflected by reductions in unit prices. Most of the evidence we have found relates to the efficiency factor for the health sector as a whole, and as a result the analysis set out in this document is largely based on the second approach.

The **first step** in this approach to deriving an efficiency factor is to decide how much more productive we can reasonably expect the NHS to become over the next 12 months. This

step takes into account all of the ways in which the NHS can provide better patient outcomes[40] within the available budgets. Our objective for this engagement document is not to choose a single figure, but instead to determine a plausible range for total efficiency. The final efficiency factor may not necessarily be within this range. We will review this between now and the autumn statutory consultation.

The key evidence that is likely to be available includes:

- expert opinions and projections about the potential for future productivity gains in the sector; and
- past productivity gains by providers in the UK and in comparable countries.

The **second step**, subject to the evidence, is to determine how potential efficiency gains are distributed throughout the different service areas of the NHS.

The **third step** is to consider the proportion of this overall efficiency potential that should be reflected in unit prices. Specifically, we need to distinguish between:

- potential improvements in productive efficiency, where providers are able to deliver substantively the same service for less – this is where potential efficiency should be reflected in unit prices; and
- improvements where providers and commissioners work together to deliver equal or better health outcomes by choosing a different mix of services that delivers higher value overall - in this case potential efficiency does not flow through to unit prices but is a result of the change in mix of services purchased by commissioners.

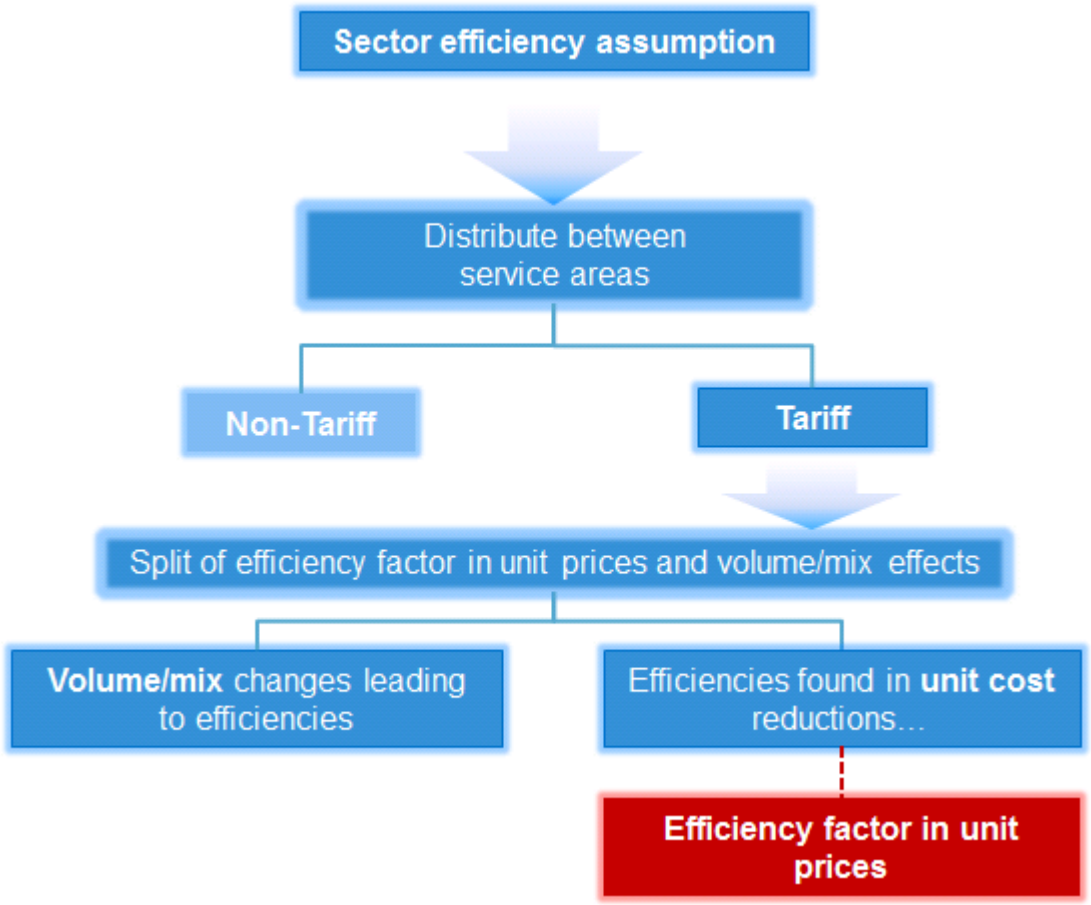
In this third step, we move beyond simply considering the potential size of efficiency gains, and consider *how* efficiency will be delivered. As part of this analysis, we may need to consider whether one of the components of efficiency gains (ie either unit cost reductions or mix effects) is more or less likely to be delivered in the short term compared with the other.

Based on these three steps, we can define a broad range for the potential efficiency factor for tariff services. While we would endeavour to use the best available evidence in these steps to define a plausible range for efficiency, there might still be considerable room for judgment in setting the final efficiency factor. However, our aim is to be as transparent as reasonably possible so as to provide the sector with a better understanding of why we form any judgments we need to make.

The process summarised above is illustrated in Figure 3-4

[40]The NHS Outcomes Framework sets out five high-level national outcomes that the NHS should be trying to improve: (i) preventing people from dying prematurely; (ii) enhancing quality of life for people with long-term conditions; (iii) helping people to recover from episodes of ill health or following injury; (iv) ensuring that people have a positive experience of care; and (v) treating and caring for people in a safe environment; and protecting them from avoidable harm. See https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/127106/121109-NHS-Outcomes-Framework-2013-14.pdf.pdf

Figure 3-4: Efficiency factor processes



We next set out the sources of evidence and process for each step.

Efficiency Step 1 – how much more efficient should the sector be in 2014/15?

In forming our proposals for the efficiency factor for 2014/15, we have surveyed the available evidence regarding the opportunities for health sector efficiency. Although there is, in our view, a wealth of commentary in the public domain on the challenges facing the NHS, there is less quantitative evidence on the available opportunities for efficiency gains.

The principal sources of evidence we have identified are:

- In 2009, DH commissioned McKinsey to identify potential productivity gains in the NHS[41]. This analysis broadly suggested sector efficiency gains of 3-4% per year were achievable over a five year period from 2008/09 to 2013/14.
- A report by the King's Fund in 2010 considered that consistent annual gains of 3-4% over the period 2010/11 to 2014/15 are "more realistic" than a previous estimate of 6% - but still "extremely challenging"[42].

[41]"Achieving World Class Productivity in the NHS 2009/10 – 2013/14: Detailing the Size of the Opportunity", McKinsey Report for DH, March 2009.
[42]"Improving NHS productivity: More with the same not more of the same", King's Fund, July 2010.

- The Nuffield Trust has engaged in a work programme in two phases. In the first phase, which is focused on assessing the scale of the NHS' financial challenge, it has set out potential initiatives that they suggest would lead to savings of £4 billion in the acute sector over the period 2010/11 to 2014/15[43], equivalent to approximately 2% per year. In the second phase, it will focus on assessing the scope for productivity gains in the sector, and we will consider any further evidence published to inform our views.
- Monitor engaged external consultants to support us in identifying improvement opportunities in the health care sector. This work will be published shortly on Monitor's website. The consultants quantified the potential efficiency gains arising from some of these improvement opportunities which could be realised over the 11-year period between 2010/11 and 2021/22.
- These sector efficiency savings sum to £15.4bn (at the low end of the range) to £25.5bn (at the high end of the range)[44]. More details are in Table 3-12 below. Measured against the 2010/11 NHS spend of £91bn, these equate to efficiency savings of between 17% and 28% over 11 years. If the savings were to be realised evenly over the 11-year period considered by the analysis, the annual efficiency gain would be between 1.7% and 2.9%. However, we note that (i) the analysis specifically states there are other potential efficiencies which are not quantified; and (ii) constant efficiency over time is not necessarily the correct assumption. It is possible to consider greater efficiency opportunities in the earlier part of the period. Therefore there are grounds for an efficiency assumption for 2014/15 in excess of the 1.7-2.9% average.

We have also considered evidence of past productivity gains by providers, with a particular emphasis on the most recent data on Cost Improvement Programmes (CIPs):

- the average CIP savings target for 2012/13 reported by providers in a survey by the King's Fund was 4.9%[45] and "the bulk" of this was achieved; and
- Foundation trusts have reported to Monitor, on average, CIP savings of 3.4% (2012/13), 4.0% (2011/12) and 3.9% (2010/11). These are percentages of operating costs.

NHS England advises that commissioner efficiency gains from the Quality, Innovation, Productivity and Prevention (QIPP) programme have been around 1-2% a year in recent years.

These two factors together suggest that recently total sector efficiency increased by 5-6% in 2012/13. Balanced against this, we also note that historic long-term NHS productivity gains have been much lower, for example ONS has estimated a 0.4% annual average productivity gain between 1995 and 2010[46].

However, we are inclined to place more weight on third party assessments of potential efficiency gains, and the more recent efficiency data, than the older data. The decade from

[43] Nuffield Trust: A decade of austerity: the funding pressures facing the NHS from 2010/11 to 2021/22
[44] These figures exclude the impact of wage freezes and real terms reductions, since the impact of wage restraint is reflected in the tariff uplift factor as described in Section 3.5.
[45] *How is the health and social care system performing? Quarterly monitoring report June 2013*, the King's Fund
[46] Public Service Productivity Estimates: Healthcare, 2010" dated December 2012 (Massey)

2000 to 2010 was a period of consistent and unprecedented growth in NHS spending. In this context, it may be reasonable to assume that the pressure on providers and commissioners to deliver efficiency gains was lower then than it is in a time of tighter fiscal constraints.

Moving from sector efficiency to looking at the efficiency factor that feeds into unit prices, we also note that recent Payment by Results tariffs have included an efficiency factor of 4% for 2011/12, 2012/13 and 2013/14. We will review data on financial and efficiency performance, and delivery of efficiency savings, between now and the autumn consultation. This will include further investigation of recent and current evidence as to the extent to which price changes or the efficiency factor have an impact upon providers' revenues.

Table 3-10: Efficiency assumptions in recent tariffs

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Efficiency	***3.0%***	***3.0%***	***3.5%***	***4.0%***	***4.0%***	***4.0%***

Source: DH[47]

For the purposes of the 2014/15 tariff, we therefore propose that a reasonable range for *sector* efficiency is 4% to 5% in 2014/15. This is based on:

- more recent experience that suggests that sector productivity gains of 5% to 6% have been achieved over a shorter term[48];
- third-party evidence on potential sector productivity gains suggests a range of 2% and 4% per annum is achievable over a period of several years – but this need not be achieved by a constant percentage each year. It could be higher in early years;
- the apparent ability of providers to absorb real price reductions of 4% per annum, which suggests that the sector as a whole is capable of efficiency gains of 4% or more; and
- our view at this stage that, although historical productivity growth in the sector has been low, this suggests considerable scope for improvement (especially in light of the high levels of investment that have been made over the decade 2000 to 2010).

Efficiency Step 2 – distribution between service areas

Tariffs in the past have typically included the same efficiency factor for tariff and non-tariff services (with the exception sometimes of specific known pressures). For the 2014/15 tariff, at least, we therefore propose to continue to adopt this approach, with the same proportionate efficiency gains across service areas. We would welcome any evidence that should inform any of the calculations in this section, including this assumption of equal efficiency gains across the sector.

[47] https://www.gov.uk/government/publications/payment-by-results-pbr-operational-guidance-and-tariffs (paragraph 27) and https://www.gov.uk/government/publications/confirmation-of-payment-by-results-pbr-arrangements-for-2012-13 (paragraph 22) for 2013/14 and 2012/13 respectively. Earlier figures from earlier years' Payment by Results tariffs.

[48] That is, 4% provider efficiencies (from CIP data) and 1% to 2% from recent annual commissioner efficiency gains.

Efficiency Step 3 – share of potential efficiency gain to be reflected in prices

As discussed above, some efficiency gains feed through directly into prices, while others relate to volumes or service mix. We separate the efficiency gains below into:

- efficiency gains that appropriately do feed into the tariff. For example, a provider improving its efficiency, utilising its inputs more effectively, would reduce its unit costs. The expectation as to the extent to which such efficiency gains can be achieved should feed directly into unit prices;
- changes to volumes or service mix. (An example of this would be improved integrated care that reduces the need for hospitalisation, with an overall saving in cost as well as improvement in quality. That efficiency gain reduces activity, and therefore payments, to secondary care directly without any change to the tariff. It would not therefore be appropriate to include that saving in the efficiency factor in the tariff, which is applied to unit prices.); and
- changes that are already handled elsewhere in the tariff calculation. Pay reductions in real terms are often counted as efficiency gains. However, pay impacts are already part of the tariff uplift, under the method described in Section 3.5. So this factor is not part of the calculation to establish the share of efficiency gains that should be reduced in unit prices.

The percentage we are looking to calculate in this step is therefore the efficiency gains that feed into the tariff as a proportion of total expected sector efficiency (for the purposes of this calculation, leaving aside changes handled elsewhere in the calculation such as pay restraint).

The principal sources of evidence we have identified are:

- Data from McKinsey (2009)[49] implies that about 50% of sector efficiency gains would come from effects that lead to providers reducing unit prices. McKinsey estimated the range of savings associated with impacts. We have classified them into whether or not they should be reflected into unit prices:

[49] Achieving World Class Productivity in the NHS 2009/10 – 2013/14: Detailing the Size of the Opportunity", McKinsey Report for DH, March 2009. On DH website.

Table 3-11: McKinsey analysis of potential health care sector efficiency gains for DH (2009)

Initiative quantified by McKinsey	Low end of range savings £bn	High end of range savings £bn	In unit prices?
Acute providers' productivity	1.9	3.0	Yes
Non-acute providers' productivity	1.3	1.9	Yes
Supply chain/ procurement	2.3	3.7	Yes
Estates optimisation	0.5	0.6	Yes
Optimising spend within care pathways	3.7	4.9	No
Enforcing PCTs' contracts/standards	1.1	1.7	No
Enhancing self care and chronic management	1.9	2.5	No
Local health economy reconfigurations [50]	0.8	1.6	Partly
Total	**13.4**	**19.9**	
Total that would be reflected unit prices	**6.0-6.8**	**9.2-10.8**	
% of total in unit prices	**45%-51%**	**46%-54%**	

- When giving evidence to the Public Accounts Committee, Sir David Nicholson said in 2010 that 40% of savings could come from "traditional efficiency" (which is relevant to the tariff efficiency factor), 40% from central initiatives (mainly wage restraint) and 20% from "service change"[51]. As the 40% from central initiatives is not relevant for the purpose of calculating the efficiency that feeds into unit prices (wages are handled in a separate part of the tariff calculation from efficiency), this statement implies that two-thirds[52] of non-central efficiencies might be expected to come from providers, reducing unit costs.

- The analysis on improvement opportunities in the health care sector carried out for Monitor (and described above) implies that, in the 11-year period to 2021/22, about 72-75% of sector efficiency gains would come from effects that are appropriate to incorporate into an assessment of the efficiency that would affect providers' unit prices. We have set out in Table 3-12 the data that underpins figures of 72% and 75%. The cost savings estimates (high and low) are taken directly from the analysis (which will be published shortly on Monitor's website). We again separated those initiatives that ought to be reflected in unit price reductions from those that ought not to. The share of sector efficiency gains that should come from providers reducing unit prices on this basis was 75% in the low savings scenario, and 72% in the high savings scenario.

  The analysis explicitly considered the quality of the evidence for each element of these savings, and a rating of Strong, Medium or Weak was allocated to each initiative depending on whether they were underpinned by a "large evidence base",

[50] There would be some unit price effect, but this will mostly *not* be in unit prices.
[51] Public Accounts Committee, March 2010.
[52] That is, 40% divided by 60%.

"some evidence base" or were "purely theoretical" respectively: these are shown as green, amber and red in Table 3-12.

Table 3-12: Analysis of potential health care sector efficiency gains for Monitor

Initiative	Low end of range savings £bn	High end of range savings £bn	In unit prices?	
Improve efficiency in acute	2.7	4.7	Yes	●
Improve efficiency in primary care	1.2	2.5	Yes	●
Improve efficiency in community care	1.2	1.8	Yes	●
Improve efficiency in mental health	0.5	1.3	Yes	●
Use cost of capital to incentivise improved asset utilisation (one-off)	4.8	7.5	Yes	●
Prevent hospitalisation through integrated care	1.2	2.0	No	●
Directly shift activity into more cost-effective settings	1.0	1.6	No	●
Patient empowerment and self-care	0.2	0.4	No	●
Decommission elective procedures of low clinical value	0.2	0.6	No	●
Stop using low value drugs and devices (pathways)	0.7	1.2	Yes	●
Move to substantially different delivery models eg	1.7	1.9	Yes	●
Total	**15.4**	**25.5**		
Total that would be reflected unit prices	**11.6**	**18.4**		
% of total in unit prices	**75%**	**72%**		

Based on these data, we consider that 50% to 75% is a reasonable share of projected sector productivity gains to include in unit prices. This is an estimate for the long run share, and does not take account of any timing effects that might be relevant to the 2014/15 tariff. We note that 50% is an older estimate, and so merits less weight than the more recent analysis for Monitor.

There are reasons to think that providers can achieve a greater share of efficiency gains in 2014/15 than the long run share of 50% to 75%. In total over the period to 2021/22, the analysis for Monitor suggests that efficiency savings of between 17% and 28% are possible, and adds that there are other potential efficiencies that are not quantified. We note that the strength of evidence for the potential gains in Table 3-12 varies by initiative[53], but even allowing for uncertainty in the package of initiatives as a whole, there appear to be significant opportunities for providers to become more efficient in the short term. The most recent evidence on efficiency from CIPs supports this. Therefore, we consider a share of 75% to 90% is appropriate for the 2014/15 tariff.

Again, we would like to receive further evidence and reasoning from stakeholders about the extent to which efficiency gains in the NHS in 2014/15 should be reflected in unit prices. We will also refine our views on this issue with more detailed analysis in the lead up to the autumn statutory consultation.

[53] Of the initiatives in Table 3-12, all have either a Strong or Medium rating, other than 'Improve efficiency in mental health'.

3.6.2 Our initial proposal for efficiency in 2014/15

At this stage we do not have a single proposal for the efficiency factor, but we will propose an efficiency factor for the statutory consultation in the autumn.

For now, based on the evidence we have reviewed, we consider an appropriate range for the efficiency factor for 2014/15 could be calculated in the following way:

- total sector efficiency of 4-5%;
- an allocation between different parts of the health sectors whereby the tariff efficiency assumption is the same as for non-tariff services; and
- 75% to 90% should be reflected in unit prices.

These inputs result in an efficiency factor in the range of **3.0% to 4.5%**. We would welcome views on this.

An efficiency factor toward the higher end of this range would be the appropriate choice if, for example, we find that providers are well placed to deliver substantial efficiency gains in the short term without significant risks to patient outcomes (eg risk of a reduction in service quality).

An efficiency factor toward the lower end of this range would be the appropriate choice if, for example, we are concerned that a more onerous target would be too disruptive for providers. This could however imply a higher reliance on mix changes to balance the budget which could create its own risks for patient outcomes (including both quality and volumes of services delivered).

Ultimately, we will propose an efficiency factor for the autumn statutory consultation based on the evidence presented here, supplemented by:

- stakeholder feedback on the evidence that we have presented;
- stakeholder views on the reasoning that we should apply in choosing an efficiency factor;
- new evidence that we collect between now and the autumn consultation; and
- further analysis of the likely impacts of setting the efficiency factor at different levels.

Subject to the evidence that we receive, it is possible that we might choose a different efficiency factor, including one that falls outside the range of 3.0% to 4.5%. The proposed range is our best estimate at this stage, and we expect to choose an efficiency factor somewhere within this range for the 2014/15 tariff, but stakeholders should be aware that new evidence and other feedback could alter that view.

Q3. The purpose of the efficiency factor 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? Please give your reasons for this answer.

DQ3. Estimating the productivity gains achievable by providers is a complex task in light of the size, breadth and variety of NHS services. We have reviewed publicly available sources but we are aware that other evidence may be available.

Are you aware of / do you have additional evidence we should consider?

We are interested in your views on all the material covered in this section.

Q4. Do you agree with the methods that we propose to use to calculate 2014/15 prices? Please give your reasons.

4 Rules and variations

This section sets out the framework within which adjustments are made to national prices and currencies, and within which local price setting negotiations will take place. The framework consists of a large number of what the Act calls “rules” and “variations”.

This framework of national and local variations, and rules for local price setting will ensure Monitor and NHS England meet our statutory duty to have regard to the differential costs incurred by providers who treat different types of patient, and the differences between providers with respect to the range of services they provide. Monitor and NHS England must have regard to these factors, in order to ensure that the prices payable for NHS services result in a fair level of reimbursement for providers (see section 119(1) of the Act).

Under Section 116 of the Act, the National Tariff may include five main types of rules and variations:

1. **Nationally determined variations to national prices** aim to make prices more reflective of local and service-specific costs and facilitate financial risk sharing between providers and commissioners. For example the Market Forces Factor.

2. **Local variation rules to regulated national prices and mandated currencies (previously known as ‘flexibilities’)** give local commissioners and providers the option to design a different currency or price for local use. The primary aim of these variations is to ensure payment approaches support better care to be delivered to patients, for example delivered closer to home or using a new technology.

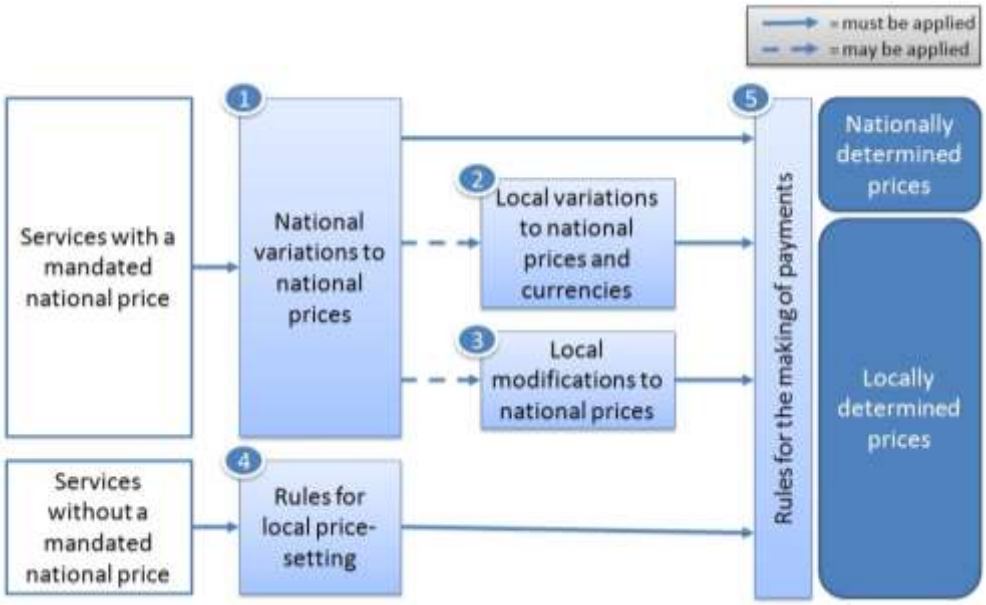
3. **Rules under which providers and commissioners can make modifications to national prices** are a new part of the pricing regime and are required under the Act. They provide scope for national prices to be modified where local circumstances make it uneconomic to provide the services in question at the national price after adjustments for mandatory variations.

4. **Rules for determining prices for services where no regulated national prices are set.** Many services, current or newly designed, will remain without a national price. In some cases, such as Mental Health services, currencies have already been developed, and the relevant rules will therefore focus on the collection of data to support local price-setting for these currencies. In other cases regulations are issued by the Department of Health and, in such cases, we will provide links to those regulations.

5. **Rules for the making of payments.** These rules will support the flow of funds between providers and commissioners, eg setting a requirement for accurate invoicing by providers.

Figure 4-1 below illustrates how these different types of rules and variations fit together, and how they are applied.

Figure 4-1: Framework of National Tariff Rules and Variations



In line with our stability approach to 2014/15 national prices, there are adjustments which are already operating for 2013/14 which we are bringing forward into the 2014/15 National Tariff. We have undertaken an exercise to categorise these adjustments in accordance with the types of rules and variations set out in the Act. A summary mapping of where these rules sit within the new framework is set out in Figure 4-2 below:

Figure 4.2: Mapping of 2013/14 PbR adjustments to NTD rules and variations

	Proposed NTD Section: Variations & Rules sub-sections				
	Locally determined variations to national prices and currencies	**Nationally determined variations to national prices**	**Local modifications**	**Rules for re-imbursement of health services with no national price**	**Rules relating to the making of payments**
Mapped 'rules' from 2013/14 PbR Guidance	Local variation rules (flexibilities)	MFF Unbundled diagnostic imaging risk sharing Maternity pathway payment risk sharing Specialised service top-up payments 30 Day readmission rule 30% Marginal Rate Emergency rule		Adult Mental Health Ambulance services Admitted Patient Care Outpatients Exclusions	

We propose that all rules set out in this section will be mandatory and subject to the National Tariff enforcement regime (see Section 6, and the separate document, *Draft Guidance on Enforcement of the National Tariff*). If local payment is consistent with the rules and variations, including the rules for local payment variations (PbR "flexibilities") and local price-setting, commissioners and providers will be in compliance with the National Tariff.

We are aware that there are currently in use many different approaches to payment – from separate payment for a particular drug to a block payment for a whole set of services. To help the sector translate their current approaches to payment to the NTD rules and variations, we have created an illustrative summary table, Table 4-1. This table should help readers understand how the NTD rules and variations differ in their application. This table reflects current policy proposals for rules and variations. As part of this engagement exercise, we are keen to understand the sector's views on these proposals:

Table 4-1: Illustration of how NTD rules and variations differ in their application

	Proposed rule that applies			
Purpose of payment	**Local Variations**	**Price Locally Determined**	**Local Modifications**	**Explanation**
Development of existing services and innovation in clinical practice	✓	?		Commissioners can choose to pay for enhanced quality of care or adopt new technologies for benefit of patients
Invest in new facilities (including estates and/or equipment)		✓		Commissioners may support investment through committing to a time limited period of additional funding for large capital outlays
Commission new services, including to deliver integrated care e.g., year of care, capitation, complete pathway		✓		Commissioners may design new service configurations they wish to purchase, which need new, local units of payment (i.e., not a national currency) and local price-setting
Reimburse for a patient casemix that differs from average e.g., more simple or more complex	✓			Commissioners would agree service specifications with providers that explicitly exclude or include patients with particular complexity factors, and so may need to adjust the national price accordingly
Shift care into a new setting, potentially closer to patient's homes e.g., into a community clinic or GP practice	✓			Commissioners may wish services to be delivered in new settings which also result in cost reduction, and so it may be appropriate that reduction in the national price is agreed to reflect the adjusted cost profile
Pay for structural issues that raise costs, such as: - Scale (e.g., small provider) - Population (e.g., homeless) - Other	TBC		✓	Commissioners and providers should work together to agree, ideally, a fair reimbursement to cover any structural cost difference between local costs and national prices. This would cover conditions that are predominantly outside of provider's control
Share volume risk for urgent and emergency care e.g., due to seasonal demand fluctuations	✓			Commissioners and providers may choose to share volume risk for urgent and emergency care because of seasonal patterns or to enable service redesign
Ensure capacity is available regardless of patient volumes e.g., volatile annual volumes		✓		Commissioners may wish to secure safe provision of care where certain clinical expertise and facilities are required regardless of patient demand levels
Control or redirect volumes where patients have choice	✗	✗	✗	Commissioners must preserve patients' right to choose under the NHS Constitution
Share year end deficit / surplus and/or seek to balance books	✗	✗	✗	A true and fair reflection of financial performance and position must be maintained for transparency

The following sub-sections cover each of the different types of rules. Each sub-section introduces and discusses the rules and variations falling under that heading that we propose to include in the 2014/15 *National Tariff Document*. Since local modifications is a new policy

provision under the 2012 Act, the proposed rules governing these are set out separately in more detail in Section 5.

Q5. Over the coming years, we intend to review all aspects of the rules set out under the PbR 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?

4.1 Nationally determined variations to national prices

The change to the National Tariff timetable and feedback from stakeholders asking for more stability in this time of change for the NHS, means we propose that the majority of provisions set out under the *Payment by Results (PbR) Guidance* in 2013/14 would be rolled forward in 2014/15. For 2014/15, there are two nationally determined variations which are under review. These are the 30% marginal rate rule for increases in the value of emergency admissions above a baseline, and the permission to share financial gains and losses following the unbundling of diagnostic imaging, both of which are set out in more detail below. However, in time, we do intend to review all aspects of the rules and variations set out under the PbR payment system.

We have divided national variations into two distinct categories below:

1. variations for circumstances outside of a provider's control; and
2. variations to share risk between providers and commissioners more appropriately.

4.1.1 Variations for circumstances outside of a provider's control

As noted in Section 3, the payment system needs to balance the competing objectives of complexity and specificity. If a payment system is very complex it will be costly to administer and likely be difficult to understand. Such a complex system may result in poor compliance with national prices. But, an overly simplistic payment system risks not providing appropriate levels of reimbursement.

The tariff currently uses a case mix based payment system, with national prices for HRGs largely based on providers' reported mean unit costs. These national prices do not allow for factors outside of a provider's control. Therefore, the proposed NTD would include national variation rules that help to adjust for these factors and alter the payment a provider receives. These rules might adjust for factors relating to unavoidable cost differences due to the location of a provider or the complexity of patients it treats. For 2014/15, these include:

- Market Forces Factor; and
- Specialised service top-up payments.

We briefly discuss each in turn but propose that the current approach adopted in 2013/14 will be unchanged in 2014/15.

The Market Forces Factor (MFF)

The MFF is designed to adjust for unavoidable cost differences between providers for land, buildings and staff costs. Adjusting national prices for the MF, may help to ensure that patients can access equivalent care, where health care costs differ between geographical areas. The MFF also influences health resource allocations to commissioners in England.

Each provider has an individual MFF payment index value. This value has historically been calculated by the Department of Health, based on the recommendations of the Advisory Committee on Resource Allocation. The payment index is applied to the national prices for each unit of activity to determine the income each provider receives for each patient. The MFF is applied to national prices after specialist top-ups and long-stay payments have been incorporated. The current MFF indices can be found within the PbR 2013/14 tariff information spreadsheet and further details on how the MFF is calculated can be found here.

We are proposing that the current MFF indices will remain unchanged for 2014/15 tariff. The exception would continue to be where organisations merge during 2013/14. These organisations will need to have a new MFF from 1 April 2014. Merging organisations should notify the DH PbR team by email (pbrcomms@dh.gsi.gov.uk) so that a new MFF value for the merged organisation can be calculated.

Provisions for patients to choose their provider are set out in the NHS Constitution. The application of the MFF to national prices should not cause commissioners to limit patients' right to choice. Commissioners will continue to be required to pay the price that has been adjusted by the MFF index value of the provider chosen by a patient.

Specialised service top up payments

Some patients with the same condition have more complex needs than others, requiring more expensive interventions or more intensive clinical supervision. This means that the costs of the care of those patients are higher. Not all providers treat the same proportion of patients who have complex needs and who require specialised activities. Specialised service top-up payments are designed to recognise the additional costs of specialised activity compared to non-specialised activity that may be captured within the same HRG, and to reimburse providers more appropriately. The top-up payment is a value by which payment calculated using national currencies and prices is multiplied. The design and calculation of specialised top-ups is informed by work undertaken by the Centre for Health Economics (CHE) at the University of York[54].

Specialised top-ups currently exist for four specialised services: specialised children, neurosciences, orthopaedic and spinal surgery. Only eligible providers can receive top-ups for specialised children's, neurosciences and spinal services. These eligible providers were determined by a panel of Specialist Services Commissioners, NHS Specialised Services and

[54] Estimating the costs of specialised care(CHE, 2011);
Estimating the Costs of Specialised Care: Updated Analysis Using Data for 2009/10 (CHE, 2011)

other NHS Organisations in 2010[55]. The specialised service top-up values, trigger lists (lists of OPCS and ICD codes that will flag activity as specialised), and eligible providers are located within the PbR 2013/14 tariff information spreadsheet. We propose that these will remain unchanged in the 2014/15 National Tariff.

Monitor and NHS England are currently examining the reimbursement of specialised services and complex patients. This work is unlikely to conclude in time to make changes to the 2014/15 tariff, so any changes are likely to be implemented from 2015/16 onwards. The work will be taken forward by a working group including NHS England, Monitor and a range of providers and commissioners.

However, we are aware that in this financial year (2013/14), some providers received additional non-PbR payments to compensate for the complex nature of the services they provide and patients they treat. If commissioners are willing to agree to additional payments in 2014/15, then this is likely to be permitted subject to the rules governing local payment variations (Sub-section 4.3) and local modifications (Section 5).

4.1.2 Variations to share risk between providers and commissioners more appropriately

The other set of circumstances where it is appropriate for the national price to be adjusted on a mandated basis is where it has been identified that financial risk should be shared between providers and commissioners. This includes circumstances where a commissioner should not necessarily pay for all activity at the full national price, and where a provider's income may need to be partially protected on a transitional basis to accommodate a price-setting methodology or currency design change.

We are proposing to maintain for 2014/15 the following existing variations from 2013/14 that are designed to share financial risk between providers and commissioners:

- 30 day readmission rule; and
- maternity pathway payments.

We are currently reviewing two existing variations from 2013/14:

- unbundled diagnostic imaging in outpatients; and
- 30% marginal rate rule for emergency admissions.

We are considering whether it may be appropriate to remove one existing variation from 2013/14:

- External beam radiotherapy and chemotherapy delivery.

These five variations, including our proposals for potential changes, are discussed below.

[55] Explanatory note to accompany 'Estimating the costs of specialised care' (DH, 2011)

30 Day readmission rule

To act in the interests of patients, hospitals should take care in planning discharges from admitted care settings. This may include coordinating with the patient's family and GP regarding medications or arranging post-discharge support in a community setting if needed. The 30 day readmission rule was introduced in 2011/12 to incentivise hospitals to limit avoidable emergency readmissions within 30 days of discharge, for example through better discharge planning and collaborative working with community and social care providers.

Providers and commissioners must work together to undertake clinical reviews of a sample of readmissions to determine the proportion that could have been avoided. This review should inform an agreement of a local readmissions threshold, above which the provider will not receive any payment. As per 2013/14, we do not propose to require providers and commissioners to undertake a clinical review in 2014/15 where there continues to be local agreement regarding the readmissions threshold. Commissioners will determine how to reinvest any savings from non-payment of readmissions.

Maternity pathway payments

In 2013/14, maternity pathway payments were introduced. These new pathway currencies meant that some new services, such as postnatal checks, were assigned national prices. This required the collection of new data through the Maternity Data Set by providers. In order to mitigate the financial impact of the new pathway payments, and to recognise that not all organisations were collecting the necessary data, providers and commissioners were asked to share any potential financial gain or loss in 2013/14.

We propose that the financial risk sharing provisions set out in 2013/14 will continue to be available for providers and commissioners in 2014/15. As in 2013/14 providers and commissioners may wish to estimate the value of maternity activity under the previous payment approach. This modelling can inform negotiations for risk sharing in 2014/15. Providers and commissioners should ensure they are moving towards implementation of national prices for pathway payments in 2014/15, as we are considering full implementation in 2015/16.

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?

Unbundled diagnostic imaging in outpatients

Some tariffs for diagnostic imaging were unbundled from outpatient attendances for 2013/14[56]. This change was made to address two concerns raised by the sector: under payment of diagnostic imaging delivered for complex patients and under provision of imaging services in some local areas. Paying separately for outpatient diagnostic imaging may also allow primary care to have more direct access to diagnostic imaging, supporting primary care clinicians to make diagnoses without a consultant referral.

[56] See Payment by Results Guidance for 2013/14, section 5 (p 51), for more detail on exactly which tariffs have been unbundled for diagnostic imaging.

In 2013/14 three areas of financial risk from the unbundling were identified:

- moving from payment for an average level of diagnostic imaging activity to payment for actual diagnostic imaging activity;
- providers increasing their diagnostic imaging activity; and
- providers increasing the reporting of diagnostic imaging, where this had been under-reported.

The following mitigations were put in place in 2013/14 to address these financial risks:

- a marginal rate of 50% of the national price was introduced for the payment of any activity above the trend growth; and
- providers and commissioners were permitted to share the risk between any expected financial gains or losses resulting from unbundling.

We propose to maintain the 50% marginal rate for activity above expected levels in 2014/15, with the expected baseline adjusted to reflect appropriate growth. However, we propose to remove the overall financial risk sharing provision. This change will support the transition towards full activity based pricing in this area.

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?

30% marginal rate rule for emergency admissions

The marginal rate rule was introduced in 2010/11 following concerns over the growth in emergency admissions. It was intended as a way of sharing the risk of growing volumes of emergency admissions and to encourage collaborative efforts from providers and commissioners to implement demand management strategies.

The rule requires that a provider receives payment at 30% of the tariff income once they have exceeded the baseline tariff income value for emergency admissions. Commissioners are expected to invest the remaining 70% of the tariff income into demand management schemes which prevent inappropriate hospital admissions by improving patient care outside of hospital. The 2013/14 PbR Guidance retained the same marginal rate rule and the same baseline year (2008/9), but included changes to increase the transparency around how the savings are used. Specifically, CCGs have to agree plans for the use of the savings with providers and NHS England area teams. According to NHS England's NHS support plan, where areas have not already agreed plans and committed funds for 2013/14, Urgent Care Boards are expected to oversee the use of the funds.

Monitor and NHS England are currently reviewing the 30% marginal rate for emergency admissions for 2014/15 as a result of feedback from the sector. We issued a call for evidence on the 13 May and are keen to gather evidence from a range of stakeholders. The deadline for evidence submissions was 10 June.

A stakeholder engagement event will be held in the summer to discuss options for the 2014/15 National Tariff, prior to a final proposal being included in the statutory consultation notice in the autumn.

External beam radiotherapy and chemotherapy delivery

Following the introduction of mandatory currencies in 2012/13, in 2013/14 national prices for chemotherapy delivery and external beam radiotherapy were introduced. In recognition of the potential challenge of moving from local to national prices for some organisations, the 2013/14 PbR Guidance made provision for a staged transition. The transitional provision expected commissioners and providers to move at least halfway from local to national prices.

Feedback suggests a number of providers are now using the national prices in 2013/14. Therefore, our proposal for 2014/15 is to remove the transitional provisions above and require that national prices are used. We are however willing to consider other options for 2014/15, including continuing the staged move to national prices. To support this options appraisal, we are currently undertaking a separate exercise with providers and commissioners to assess the financial impact of completing the transition to national prices.

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; and

c) make further progress towards national prices.

Please give reasons for your answer.

4.2 Local payment variations to national prices and currencies

The sector is facing significant challenges in delivering high-quality care sustainably, with financial constraints pressing and growing demand as our population ages. Many local commissioners and providers have told us that they want to design services differently to ensure patients receive a coordinated experience across health and social care, making integrated care a reality. We would not want the specification of national currencies and calculation of national prices to stifle changes that enable high quality care to be delivered more sustainably. Therefore we propose that the National Tariff would include rules to govern local payment variation and local price-setting (see Sub-section 4.3).

The local payment variation rules would govern when and how providers and commissioners may vary national currencies and prices to the benefit of patients. For example, a commissioner may want to have a service delivered closer to, or even inside, patients' homes. Or a provider may identify a new, innovative approach to delivering care in a less invasive way, which the commissioner wishes to commission. Paying for these service developments and innovations may involve changing the unit of payment or changing the national price. These rules for these adjustments would be set out in the National Tariff as local payment variations.

Additionally, providers may have a patient casemix that varies from the average. For example some providers do not have the clinical resources to care appropriately for complex patients and may therefore agree restrictive referral criteria with commissioners. We propose to continue to allow commissioners the flexibility to vary national prices (upwards or downwards) to reflect a provider's different casemix. For providers who have a more complex casemix than the average we propose that a local payment variation or a local modification (Chapter 5) be considered. In general, we propose that local payment variations be considered first.

In instances where commissioners would like to purchase completely different types of care for their patients, such as ongoing care coordination or the establishment of integrated health and social care teams, they are designing a new unit of payment. Designing a new unit of payment may also result in the commissioner choosing to use innovative payment approaches, such as a 'year of care' or whole pathways payment. We propose rules for local price setting (Sub-section 4.3) would govern the making of payments where commissioners design new services for patients.

Monitor's primary duty is to protect and promote the interests of patients[57]. NHS England's responsibilities are set out in their Mandate from the Secretary of State[58], Therefore, it will be important to ensure that any variations do not put the quality and sustainability of care at risk. So, in order to identify the best balance between allowing freedom to develop new payment approaches while providing some safeguards, we are undertaking a review of the current PbR "flexibilities"[59]. Because allowing local innovation in the design of payment approaches is an important policy area and one where we expect a wide range of views from stakeholders, we are also publishing a separate discussion paper alongside this document. This discussion paper has more detail and specific questions, to which we welcome stakeholders' responses.

Q6. In developing the rules and oversight for local payment variations, a balance must be struck. We want to permit innovation in payment approaches to reflect new and better ways for care to be delivered. However, we need to ensure that risk is appropriately managed across the system and that we deter inappropriate behaviour. What suggestions do you have for how Monitor and NHS England can design the rules for local payment variations?

[57] As set out in sections 62(1), 66 (1), and (2)(a) of the Act
[58] NHS England's mandate for 2013-15
[59] These are set out under Payment by Results Guidance for 2013/14Section 13

4.3 Rules for the reimbursement of health services with no national price

This sub-section of the NTD would cover the reimbursement of any services provided for the purposes of the NHS that are not covered by regulated national prices. Our view is that rules are required to govern local price-setting for these services, including, in some instances, specifying the units of purchase ("currencies") used by commissioners. Such services are provided by a range of providers in a range of settings, admitted and non-admitted, for emergency and planned care. In 2013/14 many services that were undertaken by specialist, mental health, ambulance, community and primary care[60] providers did not have a mandated national price.

The NTD rules for local price-setting may be quite detailed in some cases, setting out nationally specified currencies or rules for local price-setting. In other cases, rules may be quite general, for example requiring that locally negotiated prices are adjusted by the National Tariff efficiency and inflation factors. As with all rules set out in the National Tariff, compliance with these rules will be mandatory and subject to enforcement (see Section 6).

For a full list of all current services and currencies that would fall into this proposed sub-section of rules please see the PbR 'exclusions' lists within the PbR 2013/14 tariff information spreadsheet (tab 14 and 17). In future, we do not propose to continue to define these services and currencies as 'exclusions', as all services provided for the purposes of the NHS are now within the scope of the National Tariff.

For 2014/15, with the exception of Adult Mental Health services, we do not propose to change the 2013/14 payment approach for all NHS services without a nationally mandated price. This means that the main rule whose application will alter the local price of services without a national price would be the requirement to use the National Tariff efficiency and inflation factors for 2014/15 (see Section 3) as the basis for local negotiations.

To assist the reader and to manage the depth and breadth of scope of this sub-section within the National Tariff notice and the *National Tariff Document* itself, we propose to categorise rules in this sub-section by the following care settings:

1. acute services;
2. mental health services;
3. ambulance services and patient transport services; and
4. out of hospital services.

Below, we set out more detail regarding each of these.

4.3.1 Rules for the reimbursement of acute services without a national price

The section on local price-setting for 'acute services' will include rules that cover all services and currencies that have no national price currently undertaken in an acute care setting. This would include:

i. Specialist commissioned services without a national price; and

[60] Primary care includes care provided by General Practitioners, Community Pharmacists, Dentists and Optometrists)

ii. Specified high cost drugs, devices and procedures (previously 'excluded' high-cost drugs, devices and procedures").

Where acute services, commissioned by a CCG or by NHS England, do not have a national price or national currency, payment for these services would be determined through negotiation between providers and commissioners. In some cases the National Tariff may require that a national currency is used. National currencies may form part of the transition from locally determined payment to nationally regulated payment. For example, nationally determined currencies were in place in 2013/14 for specialist rehabilitation and critical care.

In other cases, the use of national currencies for acute services may be required without the intention to move towards national prices. This might be because the annual level of activity for these services may be too small or the costs so variable that establishing a national price may not be practicable or desirable.

For acute services without a specified national currency, payment will be made in accordance with the terms and service specifications set out in locally agreed commissioning contracts. Commissioners and providers would therefore be free to negotiate and agree both the local unit of payment (currency) and the payment approach. However, local contracts should be agreed in accordance with the NHS Standard Contract set out by NHS England.

Specialist commissioned services

NHS England is now responsible for commissioning specialised services directly. For specialised services, NHS England will publish their commissioning intentions and service specifications for specialised services over the next 6-9 months[61]. In some cases we are proposing that the National Tariff includes national currencies without national prices for these services. For example, we propose that the following currencies for specialist services would be included in this sub-section:

- Specialist rehabilitation
- Critical care – adult and neonatal
- HIV adult outpatient services
- Renal transplantation

In 2014/15 we are proposing to roll forward all national currencies without national prices that were included in the Payment by Results Guidance for 2013/14.

Specified high cost drugs, devices and procedures (previously 'excluded' high cost drugs, devices and procedures)

A number of drugs, devices and procedures are not reimbursed through national prices. Within the rules for local price-setting of acute services, we propose to include a list of specified drugs, devices and procedures. These drugs, devices and procedures were largely previously known as excluded high-cost drugs and devices.

The reason for specifying this list of drugs, devices and procedures is because national prices do not reflect the costs of delivering these clinical interventions. National prices do not

[61] http://www.england.nhs.uk/ourwork/d-com/spec-serv/

reflect the costs of these clinical interventions for two reasons. The first reason is that the intervention is new or excluded from reference costs for some other reason. The cost of a newly-approved drug or device would not have been captured in reference costs (due to the time lag of costs being reflected in prices). Other drugs, devices and procedures are only used by a small number of providers. Therefore, the second reason for specifying drugs, devices and procedures is because some clinical interventions are significantly higher cost than the average care intervention. Under a casemix classification that uses average costs for informing national prices, the small number of providers that undertake high cost interventions will not be able to recover their costs through the national prices.

Therefore we propose that the National Tariff can set out explicitly which drugs, devices and procedures are not well reflected in national prices for either of the two reasons set out above. As in previous years, this list would include only those drugs, devices and procedures that have met standard criteria. We have also taken advice from service providers, commissioners, NICE and other experts to assure the selection process.

The purpose of having a separate list is to ensure that where the listed drugs, devices and procedures are utilised in the provision of care for patients, providers and commissioners agree payment terms locally. This is consistent with our overall ambition to design and implement a payment system that promotes value for patients.

To ensure the 2014/15 NTD remains clinically relevant and supports latest clinical practice, we have undertaken an exercise to update the list of drugs, devices and procedures using the same criteria adopted in previous years. All the proposed updates for 2014/15 to the current lists (in place for 2013/14) are detailed below. If necessary, the lists will be updated again for statutory consultation later in the year.

Additions to specified high cost drugs		**Amendments to specified high cost devices**	**Deletion from specified high cost procedures**
Abiraterone	Nintedanib	The current device exclusion for 'Radiofrequency, cryotherapy and microwave ablation probes and catheters' will be amended following the introduction of the new HRG FZ89Z which includes activity where these devices are used for complex gastrointestinal tract endoscopy procedures. The specified service for 2014/15 will be 'Radiofrequency, cryotherapy and microwave ablation probes and catheters (except where used for complex Gastrointestinal Tract Endoscopy procedures)' The current device exclusion for 'Aneurysm coils and flow diverters for intracranial aneurysms' will be separated into two following feedback that the meaning of the exclusion was slightly ambiguous. The specified devices will now be 'Aneurysm coils' and 'Flow diverters for intracranial aneurysms'	The procedure "balloon assisted enteroscopy" will now map to the new HRG FZ89Z, and should therefore no longer be paid for as a separate procedure.
Alipogene Tiparvovec	Nitazoxanide		
Amikacin liposomal	Octreolin		
Apremilast	Pacritinib		
Aragam	Peginterferon Beta-1a		
Asunaprevir with Daclatasvir	Peginterferon Lambda-1a		
Ataluren (For non-cystic fibrosis indications)	Reslizumab		
	Rigosertib		
Avatrombopag	Sebelipase alfa		
Catridecacog	Secukinumab		
Cysteamine bitartrate	Selexipag		
Elosulfase alfa	Serelaxin		
Elvucitabine	Sofosbuvir		
Fostamatinib disodium	Sofosbuvir with Ledipasvir		
Gamunex	Taribavirin		
GlycoPEGylated Factor IX	Vandetanib		
Levofloxacin (when delivered via nebulisation/inhalation)	Velaglucerase alfa		
	Vemurafenib		
Lipegfilgrastim	Vercirnon		
Lomitapide	Von Willebrand factor, recombinant		
Masitinib			
Mepolizumab			

DQ7. We have updated the lists of excluded high-cost drugs and devices for 2014/15. We will consider a further update in September 2013 before Statutory Consultation. Do you have any comments on the additions and amendments to the excluded high cost drugs and devices lists?

4.3.2 Rules for the reimbursement of mental health

Use of the mental health care clusters was mandated for use from April 2012. The clusters represent the currencies for most mental health services received by working age adults and older people. This means that service users have to be assessed and allocated to a cluster by their mental health provider, and this must be regularly reviewed in line with clinical protocols. It also means that the clusters form the basis of the contracting arrangements between commissioners and providers.

In 2013/14, PbR Mental Health Guidance asked providers and commissioners to make progress in implementing the care clusters in a number of ways. Some providers have been able to agree a single local price for each care cluster with their commissioners. However, most providers have not been able to do this. As a minimum, in 2013/14, providers and commissioners were asked to agree a local price for each cluster review period, based on the local contract value. This means that for 2013/14, the global level of contract income for a mental health provider should stay the same as the 2012/13 contract value (adjusted for efficiency).

A key part of the development of the mental health care clusters has been the development of quality and outcomes metrics to support the introduction of care cluster currencies. In 2013/14, all commissioners and providers were asked to start collecting and using the measures as part of their contracts. Providers have also been asked to rebase their contracts on the basis of the care clusters and send information on local prices back to the PbR team.

In 2014/15, we propose 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. Therefore, in 2014/15, we are proposing:

- further use of quality & outcomes metrics to incentivise high-quality care;
- moving from an income guarantee to a cost and volume basis (subject to locally agreed risk-sharing mechanisms); and
- supporting the implementation of choice of provider in mental health.

DQ8. Use of the mental health care clusters was mandated 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?

Quality and outcomes

The importance of quality and outcomes measurements and their position within the mental health payment model was signalled in the 2013/14 PbR guidance by the Department of Health. The requirement for 2013/14 was to collect a range of quality and outcomes measures rather than make any attempt to link the results to payment. A range of measures were recommended including:

- quality/process indicators, eg percentage of users on CPA, intensity of care;
- clinician reported outcome measure (CROM);
- patient reported outcome measure (PROM); and
- patient experience measures, eg friends & family.

The proposal for 2014/15 is to ensure that the cluster-based payment can be varied according to the quality and outcomes for the care provided for that cluster. The actual measures used and the proportion of income would be agreed locally but we plan to issue some non-mandatory advice later in the year.

Cost and volume contracts

In 2013/14, the care clusters were implemented within the constraints of an agreement that the overall impact on contract value should be cost neutral. This is to encourage embedding of the care clusters and improved data quality without financial volatility while the quality of cost and activity data improves. Therefore, to support the implementation of choice in mental health and to make the system feel "real", the proposal in 2014/15 is to move away from an income guarantee for providers to a contract based on caseload/volume of service users. The contract would be agreed on a caseload per cluster which could then vary throughout the year, within agreed constraints, depending on the actual caseload. Again, further non-mandatory advice on this will be issued later in the year following work with stakeholders.

Patient choice in mental health

We believe that moving to a payment system based on active caseload rather than an income guarantee for 2014/15 will support the introduction of choice of mental health provider, which is planned to come into force in April 2014. Where a provider has a contract with a commissioner, the impact of choice will be reflected in the overall contract caseload. However, if a provider does not have a contract with a commissioner they will need to agree the price. The simplest approach would be to use the average price per cluster the provider has agreed with other commissioners. However, some may prefer to use other arrangements, such as agreeing different prices for admitted and non-admitted care.

Patient choice may also include some specialist mental health services, which are currently excluded from the clusters for working age adults and older people. For many of these specialist services providers will already have a price list, but actual payments will again need to be agreed between providers and the patient's commissioner.

Work is also continuing on the development of currencies for Improving Access to Psychological Therapies (IAPT), Child and Adolescent Mental Health Services (CAMHS), Secure and Forensic mental health services and Learning Disability services. These development programmes will all be reviewed for 2015/16.

4.3.3 Rules for the reimbursement of ambulance and transport services

National currencies for emergency and urgent ambulance services, were first introduced in April 2012. Four categories of ambulance services were designed and agreed with commissioners and providers:

a) urgent and emergency care calls answered – price per call;
b) hear and treat/refer – price per patient;
c) see and treat/refer – price per incident; and
d) see, treat and convey – price per incident.

The prices payable for the currencies (activities (a), (b), (c), and (d)) would continue to be locally agreed. Quality and outcome indicators must be locally agreed and included in local NHS Standard Contracts. We do not propose altering these requirements for 2014/15.

There are a range of other activities, often provided by ambulance trusts, which are not included within these currencies and the local prices for them. Payment for these services should continue to be locally negotiated separately. These activities include:

- *other urgent care services* such as: air ambulance, emergency bed services (EBS), GP out of hours, cross-border activity and single point of access telephone services (eg, 111);
- *other patient care services* such as: patient transport services, neonatal transfers, and patient education; and
- *other non-patient care services* such as: emergency planning, clinical audit and research units (CARU),chemical biological radiological and nuclear (CBRN), decontamination unites and logistics or courier transport services (eg, clinical waste).

4.3.4 Rules for the reimbursement of other out of hospital services

We believe that the *National Tariff Document*, as far as possible, should provide a clear, comprehensive and consistent overview of the payment system for NHS health care. Many out of hospital services that are currently delivered, including primary care, continuing health care, and community health services are currently outside the scope of the PbR payment system's rules for national currencies and national prices. Some of these services are governed by detailed regulations and/or good practice commissioning guidelines set out elsewhere. In other cases, very little guidance exists.

Under the Act, all payments by NHS commissioners for the provision of NHS services may be covered by the National Tariff. However, the National Tariff must be consistent with current legislative requirements relating to payment – for example the 2013 NHS regulations and directions for GMS and PMS contracts. We therefore do not intend to cover these separate payment systems in 2014/15 and the NTD will be clear that these continue to be standalone for the year.

However, as new forms of service delivery are designed, particularly to enable better coordination and integration of services across time, setting and organisational boundaries, we will need to ensure that the National Tariff is adapted to be supportive. In the future we could include rules that assist local price-setting for integrated care services that bring together primary, acute, mental health and community care. We will want to make sure these rules allow NHS commissioners to pool budgets or enter into lead commissioning

arrangements with local authorities, where there is a local desire to integrate health and social care for patients.

In the meantime, for the 2014/15 National Tariff, we propose to refer to existing payment directions and regulations for all out of hospital services without a national price:

- primary care;
- community pharmaceutical services;
- primary dental services; and
- primary ophthalmic services.

We also propose to refer to other Department of Health policies that may relate to local price-setting for out of hospital services. This is to ensure that the sector has confidence that the National Tariff is consistent with these policies and that it remains for the local commissioner to implement these policies locally. For 2014/15 we have identified the two following DH policies that we propose referring to in the National Tariff:

- any Qualified Provider; and
- personal health budgets.

By providing brief summaries, references and hyperlinks, we hope readers can use the National Tariff as a means to find the key information, regulations and guidelines, which relate to the payment for all services delivered for the purposes of the NHS. We are keen to understand whether the sector shares our view that including this information is helpful and a useful first step towards a coherent payment system for all health care services.

4.4 Rules for reimbursement relating to quality and safety standards

In addition to national prices, the NHS Standard Contract and CQUIN scheme[62] impose financial penalties and incentives on providers for the delivery of care according to certain quality and safety standards. The overall impact of these penalties and incentives is to alter the income received by a provider for a service. We are considering further how the contractual arrangements concerning penalties and incentives set out within Schedule 4 of the NHS Standard Contract and CQUIN scheme should interact with the National Tariff.

For the 2014/15 National Tariff we propose signalling that any payments made for services delivered for the purposes of the NHS must be consistent with penalties and incentives set out in the revised NHS Standard Contract and CQUIN scheme for 2014/15. This would alter the income received by a provider for some services with a nationally mandated price as well as income from locally determined payment. Providers and commissioners should continue to manage contracts as previously and enforce the contractual terms as appropriate.

[62] CQUIN = Commissioning for Quality and Innovation Scheme – see NHS England's 2013/14 guidance for more information http://www.england.nhs.uk/wp-content/uploads/2013/02/cquin-guidance.pdf

4.5 Rules for the making of payments

The Health and Social Care Act permits the National Tariff to incorporate rules for how payments are made. This might include operational issues such as:

- timeliness of invoice submission and payments;
- frequency of payments eg, monthly or quarterly;
- non-contract activity price-setting;
- cross-border patient care; and
- use of NHS number for payment purposes.

The current *Payment by Results Guidance* includes a small number of operational issues as well as some expectations around commissioner and provider conduct in relation to contract negotiations and price-setting. For the 2014/15 National Tariff we will be reviewing the operational issues and conduct requirements set out under the current PbR payment system and, where appropriate and necessary, we will continue to include operational rules and behavioural standards within the National Tariff, to ensure completeness.

Section 5 Local Modifications

The Act creates a new framework to allow prices to be modified where local circumstances make it uneconomic to provide the services in question at the price determined in accordance with the National Tariff[63]. These "local modifications" can take two forms:

- firstly, 'agreements', where a provider and commissioner agree on a proposed local modification, which Monitor is then asked to approve; and
- secondly, 'applications', where a provider and commissioner are unable to agree and the provider requests that Monitor determines whether a local modification is appropriate.

Monitor is required to publish the method it will use for deciding whether to approve an agreement or determine an application.

In April 2012, we published the report "*A methodology for approving local modifications to the National Tariff*"[64]. This report set out a proposed high-level approach for approving and determining local modifications. Monitor invited feedback from stakeholders on the issues highlighted in the report and published a summary of responses in July 2012[65]. These responses have informed the subsequent development of our proposed methodology.

We set out our proposed methodology for 2014/15 in this section. We explain Monitor's responsibilities under the Act and discuss specific issues related to agreements and applications. This section is organised into the following subsections:

5.1 legal framework for local modifications;
5.2 approach to determining whether services are uneconomic;
5.3 overview of proposed process for local modifications;
5.4 proposed methodology for agreements;
5.5 proposed methodology for applications;
5.6 annual contracting cycle and funding for local modifications;
5.7 simple example of a local modification;
5.8 potential competition issues; and
5.9 next steps.

We set out proposed conditions and mandatory submission requirements for local modifications in 2014/15 in Appendix B. These conditions and submission requirements would be likely to form part of the rules and variations section of the NTD[66].

Monitor's proposed approach to local modifications should be considered in conjunction with our proposed approach to local payment variations, as set out in Section 4.

[63] See sections 116, 124 and 125 of the Act.
[64] "*A methodology for approving local modifications to the national tariff*", Frontier Economics, April 2012. This report is available from Monitor's website: http://www.monitor.gov.uk/node/1170.
[65] See: http://www.monitor.gov.uk/node/1170.
[66] We set out our proposals for the structure of the NTD in Section 2.

Monitor welcomes views from stakeholders on all parts of our proposed methodology for local modification agreements and applications. We are particularly interested in stakeholder views in response to the questions set out in Section 7.

5.1 Legal framework for local modifications

In this subsection, we describe the legal framework underpinning Monitor's policy approach to local modifications.

The legislation governing local modifications is laid out in Chapter 4 of Part 3 of the Act. The legal framework for local modifications is principally described in sections 116, 124, 125 and 126. Monitor's requirement to publish its methodology for approving agreements and determining applications is set out in section 116(1).

The Act also requires that the proposed method must be set out in the statutory tariff consultation notice, to be published in the autumn.

Any provider of National Tariff services can agree, or apply for, a local modification, if they are able to provide evidence that a local modification is justified based on the method published by Monitor. Local modifications are therefore available to both NHS foundation trusts and NHS trusts, and to independent and voluntary sector providers. The Act allows specific prices, whether a national price or a specific price determined by mandatory rules or variations, to be adjusted using local modifications. In these cases, local modifications can be used to increase the price for a particular service. Local modifications do not apply to locally negotiated prices.

In addition to these generic requirements, the Act specifies further points which relate to Monitor's proposed methodology for local modification agreements and applications and Monitor's duty to notify NHS England and any clinical commissioning groups it considers appropriate in certain circumstances.

5.1.1 Agreements

Section 124 of the Act establishes the legal framework for local modifications that are agreed between providers and commissioners. Such *agreements* only take effect if they are approved by Monitor[67]. Under the Act, Monitor may only approve an agreed local modification if, without the modification, it would be uneconomic for the provider to provide the service[68].

Local modification agreements must specify the date from which the modification will take effect, which can be no earlier than the date on which the National Tariff took effect. Agreements must also be supported by such evidence as required by Monitor under its proposed methodology[69].

If an agreement is approved, Monitor is required to send a notice to the Secretary of State and such clinical commissioning groups, providers and other persons as it considers

[67] Section 124(3).
[68] Section 124(5).
[69] Section 124(4).

appropriate. The notice must state the modification and the date from which it takes effect[70]. The notice must also be published.

5.1.2 Applications

Section 125 of the Act establishes the legal framework for local modification *applications*. If a provider and a commissioner have failed to reach an agreement under section 124, the provider may apply to Monitor to determine whether a local modification is appropriate.

As with an agreement, an application must be supported by such evidence as required by Monitor and should only be granted if Monitor is satisfied that, without a local modification, it would be uneconomic for the provider to provide the service[71].

If Monitor determines that a local modification is appropriate, the modification would take effect on a date determined by Monitor, which cannot be earlier than the date on which the National Tariff took effect[72]. As with agreements, Monitor is required to send a notice to the Secretary of State and such clinical commissioning groups, providers and other persons as it considers appropriate, which states the modification and the date it takes effect, and is published[73].

5.1.3 Notifications of significant risk

In addition to these requirements, section 126 of the Act requires that, if Monitor receives an application from a provider that is at significant risk of breaching its licence conditions because of the configuration of local health care services, Monitor must notify NHS England and any clinical commissioning groups it considers appropriate[74]. These bodies must then have regard to the notice from Monitor when deciding on the commissioning of NHS health care services[75].

5.2 Approach to determining whether services are uneconomic

The Act states that agreements and applications should only be approved by Monitor in cases where it would otherwise be uneconomic for the provider to provide the service for the purposes of the NHS[76]. In this subsection, we explain our proposed approach for how we might determine whether the provision of a service is uneconomic for a particular provider[77]. In the following subsections, we set out how our proposed approach might be applied specifically with respect to agreements and applications.

5.2.1 Defining “uneconomic”

For the provision of a service to be considered uneconomic, we would expect the cost of providing that service to be higher than the revenue received by the provider. However, this condition is not sufficient to determine that a service is uneconomic as a provider may be

[70] Section 124(6) to (8).
[71] Section 125(3).
[72] Section 125(5).
[73] Section 125(6) to (8).
[74] Section 126(1) to 126(3).
[75] Section 126(5).
[76] Sections 124(5) and 125(3).
[77] As required under section 116(1)(d).

able to reduce its costs, while still providing the quality of service required by its commissioner. The service in question could therefore be viable without a local modification. For example, a hospital may be able to reduce the costs of providing services by improving the quality of its management or implementing cost improvement programs (CIPs).

In our view, higher costs due to inefficiency by the provider should not be taken into account when determining whether provision of a service is "uneconomic". Only higher costs which cannot be avoided by the provider would potentially justify a local modification. The critical point here is that determining whether the provision of a service is uneconomic for a particular provider requires a detailed understanding of why its costs exceed the price determined in accordance with the National Tariff. It also requires an analysis of whether the provider could reduce its costs while still delivering a reasonable quality of patient care[78].

A key principle guiding our policy in this area is therefore that local modifications should only be approved for providers where they face a structural cost difference that is beyond their control.

5.2.2 Criteria for identifying structural differences

Monitor has identified four proposed criteria for identifying structural cost differences that could provide the basis for a local modification. We propose that the difference in cost should be:

- **Specific.** It should only apply to a particular provider or subset of providers and should not be nationally applicable;
- **Identifiable.** The provider must be able to identify how the structural difference affects its reported costs and the materiality of that effect;
- **Non-controllable.** It should be beyond the direct control of the provider, either at the current time, or historically. This requirement therefore excludes differences in costs that result from past management, contracting or investment decisions by the provider; and
- **Not reasonably reflected elsewhere.** The cost difference should not be reasonably adjusted for elsewhere in the National Tariff prices, rules or variations.

Under our proposed methodology, local modifications would only be approved by Monitor in cases where the provider could demonstrate that it faces structurally higher costs that are consistent with all of the criteria outlined above.

This means that higher costs as a result of previous investment decisions or antiquated estate are unlikely to be grounds for a local modification. Our methodology is intended to identify cases where a provider faces higher costs which are structural in nature and unavoidable. Previous investment decisions that increased costs may reflect choices by management that could have been avoided. Similarly, antiquated estate may reflect a lack of investment rather than a structural feature of the local health care economy. In both such cases, we would not normally consider the additional costs to be unavoidable.

[78] Our approach to the assessment and allocation of costs for the purpose of costing patient care is set out in Monitor's "*Approved Costing Guidance*", published on 6 June 2013. We would expect providers and commissioners to have regard to this guidance when preparing supporting evidence for local modifications. (See: http://www.monitor.gov.uk/costingguidance).

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.

a) **To what extent do you agree with these proposed criteria?**
b) **Are there any specific cases which would not be eligible for a local modification under these criteria but which you believe should be allowed?**

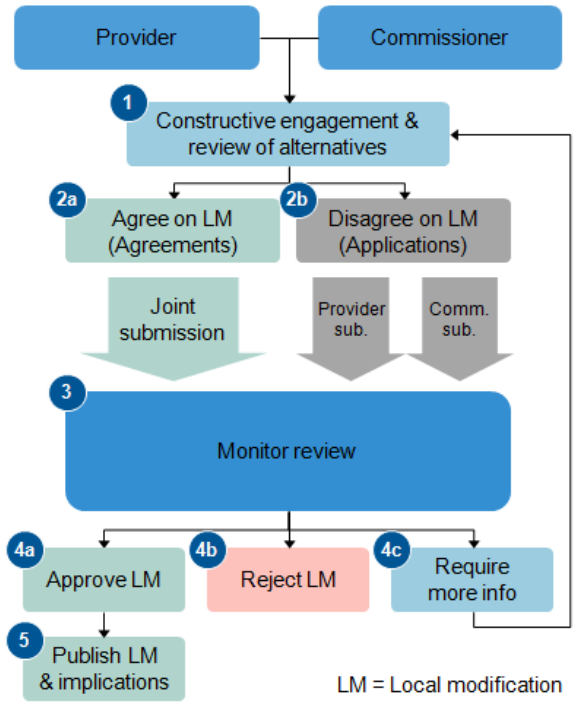
5.3 Overview of proposed process for local modifications

Our proposed methodology for local modifications is intended to encourage agreements between providers and commissioners where such agreements are in the best interests of patients. As part of our proposed methodology, we expect providers to try and reach an agreement with commissioners before submitting an application to Monitor[79]. We also expect providers and commissioners to engage constructively with each other to review alternative provision models and other options. On this basis, our proposed policy is to only consider local modification applications in cases where the provider can demonstrate that it has already tried to reach an agreement with the commissioner and has considered alternative ways of providing the service.

Figure 5-1 below provides an overview of the process we propose that providers and commissioners should follow to reach an agreement or, if they cannot agree, the process of making an application to Monitor.

[79] This is consistent with condition P5 of the Monitor licence for licensed providers, which requires providers to engage constructively with their commissioners, with a view to reaching a local modification agreement. We also expect non-licensed providers to try and reach an agreement before submitting an application.

Figure 5-1: Overview of proposed process for local modification agreements and applications



1. Constructive engagement should include analysis of the cause of deficit. Providers and commissioners should consider alternative systems for provision including local payment variations
2a. If the provider and commissioner agree on the need for a LM they should prepare a joint submission based on the methodology proposed by Monitor
2b. If the provider and commissioner cannot agree, after constructive engagement and proper review of alternatives, the provider may submit an application to Monitor. The application must be based on Monitor's proposed methodology and supported by evidence. The commissioner will be able to respond
3. Monitor will review the submissions it receives from providers and commissioners based on its proposed methodology
4. Monitor may approve the LM, reject the LM or request further information in support of the agreement or application for an LM
5. If approved Monitor must publish details of the LM and will also set out clearly the implications of the LM for other providers

As shown in Figure 5-1, our proposed process would require joint submissions from providers and commissioners in the case of agreements and sequential submissions in the case of applications.

Monitor can only approve agreements or applications in cases where it is satisfied that the service or services in question would otherwise be uneconomic. We would expect the information submitted to us by providers and commissioners to meet the requirements of our proposed methodology as set out below. In cases where insufficient evidence is provided, we may ask for further information from providers or commissioners.

Monitor is aware that certain unavoidable, structural differences in costs may affect multiple services. In such cases, Monitor would consider, and actively encourage, local modifications that cover multiple services. Submitting an agreement or application which covers multiple services is likely to be more cost effective for the provider and commissioner, and for Monitor.

5.4 Proposed methodology for agreements

In this subsection, we set out our proposal for the conditions that would need to be fulfilled before we would approve a local modification agreement. We also describe the supporting evidence requirements for an agreement and our publication obligations.

We plan to publish supporting guidance on implementing our proposed methodology for informal stakeholder engagement later this year. This guidance will provide more information on how providers and commissioners might assess whether a local modification is appropriate and if so, the level of local modification that should be applied.

5.4.1 Proposed conditions for agreements

Monitor's proposed methodology for approving agreements is based on three proposed conditions that would be included in the NTD. These conditions are as follows:

1. *The provider and commissioner agree and can provide supporting evidence that without a local modification, it would be uneconomic, based on the criteria set by Monitor, for the provider to provide specific NHS services at the prices determined by the National Tariff ("the National Tariff price").*
2. *The provider and commissioner have considered alternative means of providing the services and are satisfied that the relevant services cannot be provided at the National Tariff price while still providing a reasonable quality of patient care.*
3. *The provider and commissioner agree and can provide supporting evidence that the proposed modification reflects a reasonably efficient level of cost, given the structural differences faced by the provider, and that the services are of a reasonable quality (or would be if the modification were approved).*

Monitor would encourage agreements between a provider and multiple commissioners or a lead commissioner acting on behalf of multiple commissioners.

We are currently considering how agreements would apply in cases where a provider provides the same service to multiple commissioners, but only some of those commissioners are willing to agree to a local modification.

DQ9. What issues might arise if lead commissioners were to agree local modification agreements with providers on behalf of groups of commissioners?

We are also considering whether it would be appropriate to set a minimum value for agreements to ensure that resources are focused on the most important cases. However, we are also mindful that the costs of submitting an agreement would be likely to deter low value agreements. We would welcome views from stakeholders on this issue.

5.4.2 Supporting evidence for agreements

Under the Act, an agreement submitted for approval must be supported by such evidence as Monitor may require[80]. We propose that providers and commissioners would be responsible for developing the evidence base and analysis required to justify their proposed local modification before submitting an agreement for Monitor's approval.

We propose that each condition for agreements will be supported by pro-forma templates and joint self-certification declarations signed by both the provider and commissioner. Appendix B indicates the sort of information that we would require providers and commissioners to submit. This is likely to include:

- a list of the services that would be affected by the proposed local modification, the National Tariff prices that apply to those services, and the proposed modifications to

[80] Section 124(4) of the Act states that agreements should be supported by such evidence as Monitor may require.

those prices, as well as the proposed start date and duration of the local modification agreement[81];
- evidence that the provider and commissioner have considered alternative options of delivery for the service(s) affected by the proposed local modification; and
- an explanation of the structural differences faced by the provider and evidence to demonstrate that the proposed modification reflects a reasonably efficient level of cost, given those structural differences. We would normally expect this to include both analysis of the providers own costs and comparative analysis based on cost data from other providers, either using published reference cost data or other sources.

We are currently considering the level of detail that would be required in the pro-forma templates. Monitor proposes to take a proportionate and risk based approach to reviewing joint submissions and may, where we consider it appropriate, request further supporting evidence. Any evidence requested by Monitor should be submitted by providers and commissioners within a reasonable time period to be agreed with Monitor.

5.4.3 Publication requirements for agreements

When an agreement is approved, the Act requires Monitor to publish a notice specifying the modification and the date on which it takes effect. In complying with this requirement, we propose to publish the following information:

- the name and location of the provider and commissioner or commissioners covered by the agreement that has been approved by Monitor;
- the start date and duration of the agreement;
- a list of the services subject to the modification and the reason for the modification as well as the prices before and after the modification; and
- any implications of the agreement that Monitor considers to be relevant to other providers and commissioners.

5.5 Proposed methodology for applications

Our proposed methodology for applications is based on the same core principles as our methodology for agreements. However, there are features of local modification applications that mean that the same methodology would not be appropriate. In this subsection, we set out our proposed methodology for determining whether or not to grant applications. We also describe the supporting evidence requirements for an application and our publication obligations.

As explained above, we plan to publish supporting guidance on implementing our proposed methodology for informal stakeholder engagement later this year.

[81] The local modification agreement should not start before the national tariff takes effect and in 2014/15 should not continue for longer than the duration of the tariff (ie one year in 2014/15). Monitor will not set prices for 2015/16 until after the 2014/15 tariff takes effect. As a result we will not be in a position to approve agreements for 2015/16 until the 2015/16 tariff has been published. However, we expect agreements from 2014/15 to be approved more quickly in 2015/16 based on previous submissions as well as further submissions if required.

5.5.1 Additional requirements proposed

Applications are only available to providers who have already tried to reach agreement with their commissioners[82]. To ensure that providers engage constructively with commissioners, we propose that providers must submit evidence of such engagement in order for us to consider their application. Additionally, condition P5 of the Monitor licence requires licensed providers to engage constructively with their commissioners, with a view to reaching a local modification agreement.

To take into account possible cross-subsidies within the National Tariff, where providers receive a price that is greater than cost for some services but less than cost for others, Monitor proposes to restrict applications to providers that are in material and sustained deficit at an organisational level. This condition could be removed in future if Monitor can be satisfied that cross-subsidies are properly addressed by other parts of our pricing methodology. Under our current proposals, we would further expect the provider to be in deficit on the provision of services with mandated National Tariff prices. In exceptional circumstances, we may consider cases that do not comply with this condition, in particular, if there is strong evidence that refusing the application would cause significant harm to patients.

Furthermore, under our proposed methodology, only services which are designated as Commissioner Requested Services (CRS) (in the case of licensed providers) or services which the provider cannot reasonably stop providing (in the case of non-licensed providers) would be eligible for a local modification application. Again, in exceptional cases, we may consider cases that do not comply with this requirement. Agreements are not subject to this restriction. This means that a commissioner can choose to support non-CRS (or equivalent) services with an agreement if it wishes to do so, provided that the agreement meets the Monitor conditions[83].

Monitor published guidance on designating Commissioner Requested Services and Location Specific Services in March 2013. This guidance also provides advice on exploring alternative means of provision and de-designating services[84].

5.5.2 Proposed conditions for applications

Our proposed methodology for applications is based on the following six conditions that would be included in the NTD:

1. *The applicant provider must identify the specific NHS services requested by the commissioner which are uneconomic for it to provide at the National Tariff price, based on the criteria set by Monitor.*

[82] See section 125 of the Act.
[83] We note that previously term “mandatory services” for Foundation Trusts are currently being “grandfathered” to CRS. As such, most NHS services contracted with Foundation Trusts on 1 April 2013 (or the date of Foundation Trust authorisation, if this is later) will be designated as CRS. However, commissioners may choose to undertake a review of which services should be designated as CRS earlier than 2016 and providers can apply to Monitor to request the de-designation of particular services under certain circumstances.
[84] See: *Guidance for commissioners on ensuring the continuity of health care services; Designating Commissioner Requested Services and Location Specific Services*, 28 March 2013. (http://www.monitor.gov.uk/home/news-events-publications/our-publications/browse-category/guidance-health-care-providers-and-co-19).

2. *The applicant provider must be able to demonstrate that it has sought to agree a local modification with the commissioner and has considered alternative means of providing the services at the National Tariff price.*
3. *The applicant provider must not be able to cease to provide the services for which the local modification is requested.*
4. *The applicant provider must have a sustained and on-going deficit at an organisation level and on National Tariff services overall.*
5. *The applicant provider must provide evidence to demonstrate that the deficit on National Tariff services is driven by structural differences in the provider's costs which are not already reasonably reflected in the National Tariff prices, rules or variations.*
6. *The applicant provider must propose a modification to the National Tariff prices of the services and provide evidence to show that the proposed modifications reflect a reasonably efficient level of cost, given the structural differences faced by the provider, and that the services are of a reasonable quality (or would be if the modification was approved)*

In applying these conditions, Monitor proposes to limit the total value of local modifications approved for a particular provider to the lesser of the deficit at an organisational level and the deficit on National Tariff services overall. This approach is intended to take into account possible cross-subsidisation between services by the provider.

To ensure that Monitor focuses resources on the highest priority cases in 2014/15, we are proposing *de minimis* criteria for the materiality of the deficit faced by the provider. Monitor is currently considering a range of options for the minimum level of deficit of between 2% and 5% of total revenues. This range is based on the level of efficiencies achieved by Foundation Trusts through Cost Improvement Plans (CIPs) between 2009/10 and 2011/12 and Monitor's assessor case efficiency requirements for 2013/14 and 2014/15[85]. We propose to consider cases that do not comply with this condition in exceptional circumstances, in particular, where there is strong evidence that refusing the application would cause significant harm to patients. We welcome views on our proposed *de minimis* criteria.

In 2014/15 we would expect any provider submitting an application to be able to demonstrate a deficit equal to or greater than the *de minimis* threshold for the financial year for 2013/14.

Q8. Given the potential cross-subsidisation between different tariff services, Monitor is proposing to restrict local modification applications to cases where the provider cannot cease to provide the service and where the provider is in deficit on tariff services and at an organisational level. (These limitations do not apply to agreements).

[85] Actual levels of CIPs achieved by Foundation Trusts were 2% in 2009/10, rising to 3.9% in 2011/12. Monitor's assessor case efficiency requirements were 4.5% in 2012/13 and 5% in 2013/14 and 2014/15. (See: http://www.monitor.gov.uk/about-nhs-foundation-trusts/nhs-foundation-trust-performance/planned-performance/review-nhs-foundati).

To what extent do you agree with our outlined method to restrict eligibility for local modification applications?

DQ10. Monitor proposes to restrict local modifications applications to providers with a sustained and on-going deficit at an organisation level. Monitor is currently considering a range of options for the minimum level of deficit of between 2% and 5% of total revenues. What would you consider to be the appropriate minimum level of deficit for this purpose?

If an application for a local modification is successful, Monitor must determine the date from which the modification will take effect. In most cases we propose to make applications effective from the start of the following financial year to allow commissioning budget allocations to be updated to reflect the modification, subject to any significant changes in the National Tariff. In exceptional cases, in particular where the delay of the local modification would cause significant harm to patients, Monitor would consider making the modification effective from an earlier date.

Once determined by Monitor, a local modification application would be payable by all commissioners that purchase the relevant services from the provider in question.

5.5.3 Supporting evidence for applications

Under the Act, an application must be supported by such evidence as Monitor may require[86]. We propose that providers will be responsible for developing the evidence base and analysis required to justify their proposed local modification, before submitting an application to Monitor.

For each of the conditions listed in 5.5.2 above, we would require detailed submissions from the provider making the application. Appendix B indicates the sort of information that we would require providers to submit when making an application. This is likely to include:

- details of the services that would be affected by the proposed local modification, the current prices that apply to those services (after taking into account all applicable variations), and the proposed modifications to those prices;
- evidence that the provider has sought to engage constructively with the relevant commissioner(s) and has tried to agree a local modification agreement prior to submitting a local modification application;
- evidence that the provider is unable to cease to provide the relevant services;
- evidence that the provider is in deficit at an organisational level and on National Tariff services overall;
- an explanation of why the provider considers particular services to be uneconomic without a local modification and the nature of the structural differences in costs causing those services to be uneconomic; and
- evidence the proposed modifications to National Tariff prices reflect a reasonably efficient level of cost for providing the services, including benchmarking analysis

[86] Section 125(2) of the Act states that applications should be supported by such evidence as Monitor may require.

against an appropriate comparator set and detailed analysis of the providers own costs.

In addition to these submissions from providers, commissioners would also be given an opportunity to provide Monitor with their own submissions or respond to specific questions from Monitor.

5.5.4 Publication requirements for applications

When an application is granted, the Act requires Monitor to publish a notice specifying the modification and the date on which it takes effect. In complying with this requirement, we propose to publish the following information:

- the name and location of the provider covered by the application that has been approved by Monitor;
- the start date and duration of the application;
- a list of the services which are subject to the modification and the reason for the modification as well as the prices before and after the modification; and
- any implications of the application that Monitor considers to be relevant to other providers and commissioners.

DQ11. What challenges might providers face in preparing the information required by Monitor, both with respect to the availability of data and the time and cost of providing the required evidence?

DQ12. What issues would providers face in determining the deficit/surplus at the individual HRG level and, in the case of applications, for tariff services overall and the provider overall?

DQ13. Is there any other relevant information which we should consider but would be unlikely to be taken into account under the approach proposed by Monitor?

5.6 Annual contracting cycle and funding for local modifications

In this subsection, we explain how we would expect local modifications to fit into the annual contracting cycle for providers and commissioners under our proposed methodology and the implications of our proposed methodology for funding.

5.6.1 Annual contracting cycle

Requests for approval of local modification agreements and applications cannot be submitted to Monitor until after the NTD is published. We would normally expect to publish the NTD in the third quarter of the financial year.

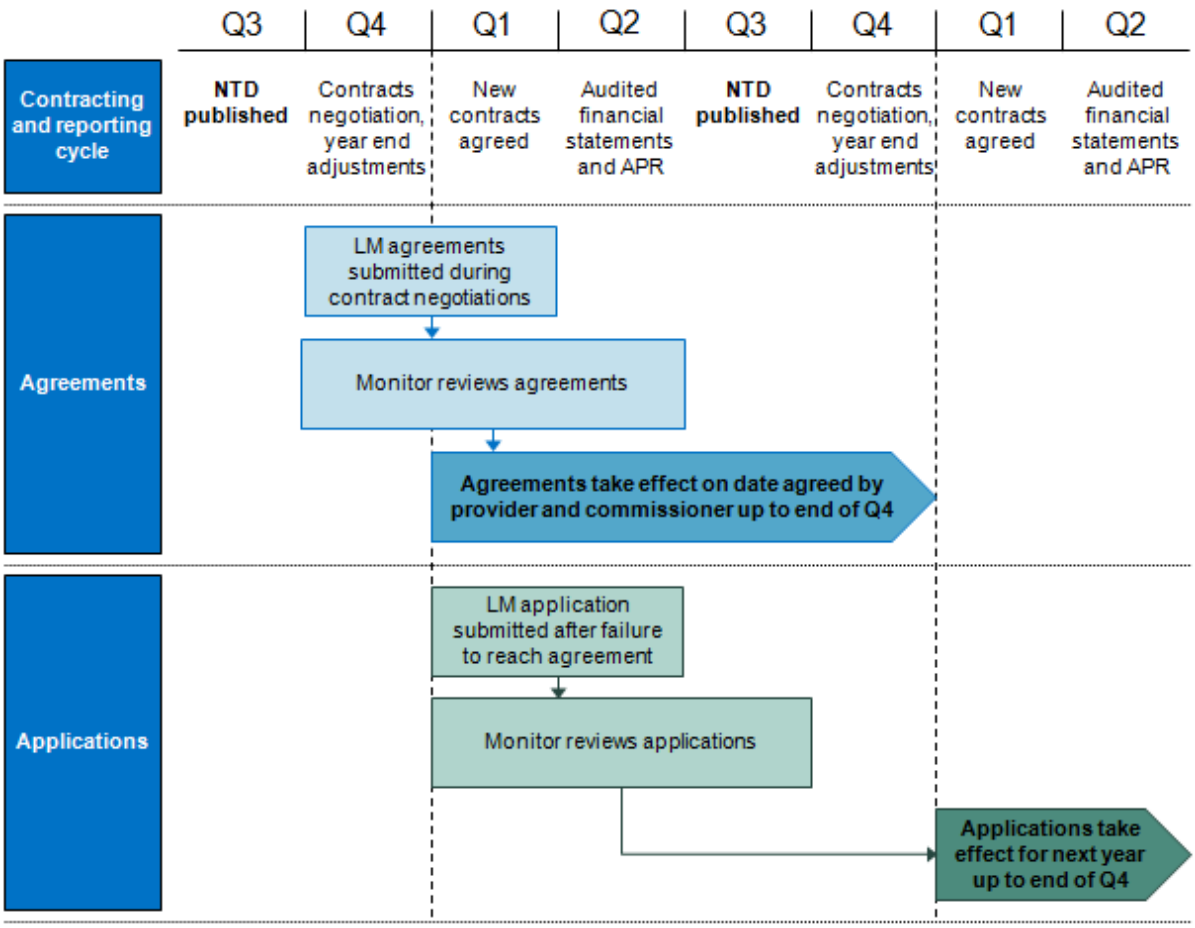
We would expect providers and commissioners to consider local modification agreements as part of their annual contracting negotiations after the National Tariff is published. This process should normally be completed before the tariff comes into effect at the start of the next financial year (although in some cases, contracting negotiations may continue into the beginning of the next financial year). We therefore expect the vast majority of agreements to

be submitted before or just after the start of the financial year when the National Tariff takes effect. Monitor would still consider agreements submitted later in the financial year, but expects the volume of agreements after this period to be limited.

Under our proposed methodology for applications, a provider can only submit an application to Monitor if it has already tried to reach agreement with the commissioner. In addition, the provider should be able to provide reliable information on its financial performance in the previous financial years, and its current and forward looking plans. We note that most providers publish their audited financial statements in the second quarter of the financial year and prepare forward-looking plans at around the same time. Foundation Trusts, for example, submit annual plans to Monitor during this period. Monitor therefore expects to receive most local modification applications in the first half of the year, after providers have been unable to reach agreement on a modification with their commissioners and once they have reliable financial data for the previous financial year available.

Our understanding of the annual contracting cycle and our proposals on how local modifications fit into that cycle are- summarised in the figure below.

Figure 5-2: Proposed annual cycle for local modifications



Note: Monitor would also allow agreements to be submitted outside of the period illustrated in this figure, although we would expect the volume of agreements at that time to be low.

We welcome comments on the proposed timing of agreements and applications and how they could fit into the annual contracting cycle.

5.6.2 Funding for local modifications

Local modification agreements and applications can increase prices above the National Tariff level. This means local modifications have the potential to increase overall funding requirements for commissioners if the volume of other services commissioned does not change. However, in some cases, the increase in price on specific services resulting from a local modification may replace other funding flows which had previously taken place between the provider and commissioner, including funding flows which were outside of the scope of the NTD.

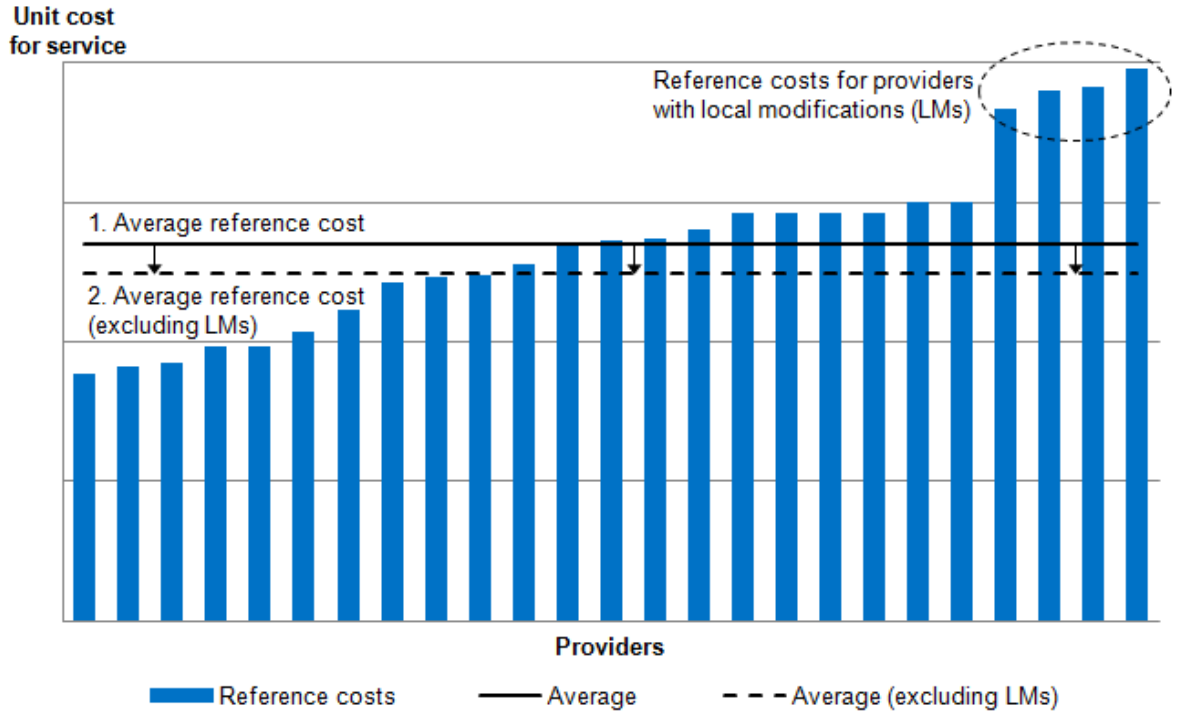
We note, at this point, that the introduction of the local modifications policy marks a step towards greater transparency in the flow of funds between providers and commissioners. Increased transparency over time should enable Monitor to develop a greater understanding of specific structural issues facing providers and this in turn could feed into our long-term pricing strategy. Greater transparency also has the potential to encourage efficiency improvements by providers.

In the case of agreements, the effect of local modifications on funding requirements is unclear and depends on whether the agreement replaces previous funding flows or creates new funding requirements for the commissioner. However, we would expect commissioners agreeing to a local modification to have taken any additional funding requirements into account in their budgets and planned spending.

In the case of applications, it is possible that Monitor may decide to grant a local modification that has the effect of increasing overall funding requirements for the commissioner, unless the commissioner makes changes to its planned spending on other services.

In light of these issues, it may be appropriate to consider how to take local modifications into account when setting prices in future. We recognise that providers in receipt of a local modification for a particular service have structurally higher costs than other providers. Consequently, it may not be appropriate to include their reference cost data when calculating the reference cost indices that are used to set national prices. Excluding providers with structurally higher costs would reduce average reference costs, and therefore national prices as currently determined. Figure 5-3 below illustrates the effect of excluding providers with local modifications.

Figure 5-3: Excluding providers with local modifications from calculation of average reference costs



We are still developing our thinking in this area and welcome views on how information from local modification agreements and applications should be taken into account by Monitor when setting prices in future.

5.7 Simple example of a local modification

In this subsection, we work through a simple, hypothetical example of how a local modification might be used by a provider and commissioner. We provide further guidance on the type of information that we would expect providers and commissioners to provide for local modification agreements and applications in Appendix B.

Example: Agreement between a rural, isolated provider and a commissioner

A rural and isolated provider believes it faces structurally higher costs as a result of economically sub-optimal scale for certain groups of services. The provider approaches its lead commissioner who agrees to consider whether a local modification would be appropriate using the methodology published by Monitor in the NTD.

Agreements condition 1 – Is the service uneconomic?

To be eligible for a local modification, the provider and commissioner must establish whether the provision of the services in question would be uneconomic without a local modification. This means that the provider and the commissioner must first agree upon the costs associated with the services in question. This is likely to involve detailed analysis of cost data. If the unit costs are higher than the National Tariff price, after applying all applicable

rules and variations, the provider and commissioner must consider whether the provider faces higher costs due to unavoidable, structural differences, using the criteria set out by Monitor.

The figure below shows how the provider and commissioner might evaluate the costs faced by the provider in this example.

Figure 5-4: Example of test for structural difference for an isolated rural provider

	Criteria	Evaluation of higher costs using criteria	Decision
1	Specific	✓ Geographical location and local population is specific to the provider, even though other providers may face similar problems	✓ Eligible for a local modification
2	Identifiable	✓ The provider can identify why its costs are higher than other providers as a result of its scale and isolated location, based on analysis of its costs	
3	Not controllable	✓ The provider cannot control the characteristics of its local population or geographical location	
4	Not adjusted for elsewhere	✓ MFF takes into account regional differences in input costs such as staff wages and building or land rents. However, MFF does adjust for low scale or isolated locations	

The figure above shows that the costs faced by the rural isolated provider appear to be higher than the National Tariff as a result of unavoidable, structural differences that are specific to the provider and are not reasonably adjusted for elsewhere.

Agreements condition 2 – Have the provider and commissioner considered alternative ways of providing the service?

The provider and commissioner must consider whether the service is appropriately specified and whether there is an opportunity to redesign the delivery of the service. If an alternative model of delivery could reduce costs while still providing a reasonable level of patient care, the provider and commissioner should consider this before agreeing a local modification.

Agreements condition 3 – Does the proposed modification reflect a reasonably efficient level of cost, given the structural differences faced by the provider?

The provider and commissioner must consider whether the proposed price reflects a reasonably efficient level of cost for providing the service required by the commissioner. The provider should undertake reasonable analysis to demonstrate its efficiency.

For example, the provider could benchmark its costs against other providers facing similar structurally higher costs. This benchmarking could be performed at the level of a whole provider, a specific department or specific currencies. To approve a local modification, Monitor would expect the provider to have costs that are similar to the costs faced by an appropriate comparator set. The provider may also consider whether its service delivery model is consistent with best practice models for the particular service or services in

question. Operational statistics such as efficiency of bed usage, may also form part of an assessment of whether a provider is reasonably efficient. This analysis should be supported by financial reporting and cost data from the provider.

The commissioner must be satisfied that the local modification is not being used to fund avoidable inefficiency. If the commissioner considers that the provider is not reasonably efficient, then a local modification should only be agreed up to the level of cost that would be incurred by an efficient provider facing the same structural cost difference.

Monitor's decision
To approve the agreement, Monitor must be satisfied, based on our published methodology, that the services in question are uneconomic. Under our proposed methodology, this means that the provider and commissioner must be able to provide sufficient evidence for Monitor to be satisfied that the local modification complies with the conditions set out above.

5.8 Potential competition issues

Monitor has a responsibility to safeguard choice and prevent anti-competitive behaviour which is against the interests of patients. As part of the development of our proposed methodology for local modifications, we have considered whether the methodology could encourage behaviour that is against the interest of patients.

If local modification agreements and applications do not reflect genuine unavoidable, structural differences in costs, it is possible that they could distort competition between providers, or potential providers, for example, by over-reimbursing on provider in an area relative to others. To mitigate this risk we plan to publish guidance on the implementation of our proposed methodology for identifying structural differences in costs.

However, local modification agreements and applications may still have unintended consequences or create perverse incentives for providers or commissioners which could lead to a distortion of competition in certain circumstances.

If this was the case, interested stakeholders, including providers, commissioners and patient groups, could complain to Monitor under the Procurement, Patient Choice and Competition Regulations[87].

The incentives created by local modifications are likely to vary depending on, for example, the parties involved and the characteristics of the area. In light of this, Monitor's proposed approach is to consider the impact of a local modification on competition on a case-by-case basis[88].

DQ14. Are there any circumstances in which local modifications agreements and applications are likely to:

[87] The National Health Service (Procurement, Patient Choice and Competition) (no 2) Regulations 2013 (SI 2013 No.500).
[88] Monitor's approval of a local modification would not preclude us from investigating any other conduct or behaviour by providers or commissioners which may distort competition in relation to the services covered by the local modification.

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 health care economy overall; or**
c) **cause any other unintended detrimental consequences?**

Please give details.

5.9 Next steps

Monitor is currently considering next steps for the development and implementation of our proposed policy for local modifications.

5.9.1 Supporting guidance

We plan to publish supporting guidance on local modifications for informal consultation later this year. This guidance is intended to help providers and commissioners to apply our proposed methodology. We are still considering the type and depth of guidance required and are seeking the views of the sector on what would be most helpful. Possible areas on which additional information and advice may be made available include:

- Advice on how payment structure and terms should be drawn up;
- Pro-forma templates and more detailed information on submission requirements;
- Specific requirements on costing information;
- Possible approaches to benchmarking analysis;
- Guidance on agreeing local modifications with lead or multiple commissioners; and
- Worked examples that illustrate cases of good practice and cases which would be rejected by Monitor.

Monitor would welcome views on these areas and other suggestions on what it would be helpful to include in any supporting guidance on local modifications.

5.9.2 Working with providers and commissioners

Monitor would like to work with stakeholders to develop its proposed methodology for local modifications. In particular, we would like to test parts of the methodology with providers and commissioners who are interested in working with Monitor. If you are considering how local modifications could be used in your local health care economy and are potentially willing to engage with us on these issues, please indicate this in your response to this consultation.

Monitor's preference is to work jointly with providers and commissioners to test parts of our proposed methodology, focusing specifically on the following areas:

- data requirements and analysis;
- exploration of alternative means of service provision; and
- the identification of evidence to support the existence of a structural cost difference, and to quantify the impact.

We would like to undertake this engagement as soon as possible.

Q9. The Health and Social Care Act requires Monitor to publish its methodology for deciding whether to approve local modifications.

a) **What are your views on the proposed methodology for calculating local modifications?**
b) **Do you foresee any challenges with the implementation of this methodology?**

DQ15. How might local modifications impact the incentives of providers and commissioners?

6 Enforcement of the National Tariff

6.1 Introduction

The Act requires that the prices payable for NHS health care services comply with the National Tariff and compliance with the National Tariff will be written into standard contracts for NHS services. Monitor and the NHS Trust Development Authority (NHS TDA)[89] have powers to enforce compliance with the National Tariff. NHS England does not have specific powers to enforce the National Tariff, although it has powers under the National Health Services Act 2006 to take action where a CCG is failing to discharge its duties properly.

Monitor has published guidance on the general approach that Monitor and the NHS TDA propose to take to enforce compliance with the National Tariff by health care providers and commissioners (NHS England and CCGs – see www.monitor.gov.uk/pricing). The draft guidance explains:

- how Monitor may enforce the National Tariff with licensees and commissioners;
- how Monitor and the NHS TDA may enforce the National Tariff with NHS Trusts; and
- that NHS England may take action where a commissioner does not comply with the National Tariff and/or does not comply with Monitor's direction to comply with the National Tariff;
- that complying with the local payment variation rules will be complying with the National Tariff.

Monitor intends to conduct price regulation in a manner that is as predictable and transparent as possible and to be supportive of providers and commissioners as they seek to comply with the National Tariff. Monitor aims to fulfil this intention both in the way we develop and then establish the National Tariff and, in our subsequent approach to enforcing the National Tariff.

6.2 What the guidance will cover

The approach to enforcement of the National Tariff will evolve over time as evidence improves about the role for pricing in supporting the design and delivery of services that protect and promote the interest of patients.

Monitor is aware that recently there may have been some occasions of non-compliance with the DH (PbR) Guidance. While the PbR guidance currently allows for payment modifications to be made if they follow the flexibilities guidance, there is limited awareness and low use of the flexibilities.[90] We are therefore reviewing the existing flexibilities guidance to develop local payment variation rules that permit and support local innovation in payment approaches within clear parameters.

[89] The NHS Trust Development Authority (NHS TDA) is a Special Health Authority, established on 1 June 2012 by an order made under section 28 of the National Health Service Act 2006 (Statutory Instrument 2012 No. 901). The NHS TDA's functions are to oversee the performance of NHS Trusts in England to deliver high-quality care, including assurance on clinical quality, governance and management of risk in those Trusts and it assists them to become sustainable organisations able to apply for authorisation as a Foundation Trust.

[90] Source: Research by NHS Institute for Innovation, which was commissioned by DH's Innovation Health and Wealth workstream.

The National Tariff will include local payment variation rules which can allow providers and commissioners to vary national currencies or prices in certain circumstances where this protects and promotes the interest of patients. Complying with the local payment variation rules will be complying with the National Tariff. To oversee the use of local payment variations and build the evidence of local practice Monitor may request to be informed or to approve the local payment variations – this is explained in section 4 on rules and variations.

Section 5 explains the process for commissioners and providers to agree a local modification to a price and what to do where commissioners and providers have been unable to agree a local modification. Where a local modification is approved by Monitor, whether it is based on agreement between the commissioner and provider or is based on an application by a provider, using that approved local modification will be compliant with the National Tariff.

Monitor wants to facilitate compliance with the National Tariff. To assist providers and commissioners, it will put in place processes to offer informal advice and to respond to queries on the tariff made by commissioners and providers.

6.3 What the guidance will not cover

Monitor's powers to enforce compliance with the National Tariff will not come into effect until Monitor publishes the National Tariff.

The NHS TDA has power to enforce its accountability framework with NHS Trusts from 1 April 2013. This includes compliance with the current PbR Guidance for NHS health care services through the pricing licence conditions that are mirrored in the NHS TDA's accountability framework. This will not be covered in the guidance. When the National Tariff comes into effect, Monitor and the NHS TDA will work together to ensure NHS Trusts comply with the National Tariff.

NHS England has powers in relation to the exercise of functions by CCGs from 1 April 2013. This includes requiring CCGs to use the NHS Standard Contract, which requires payment in accordance with the current PbR Guidance for NHS health care services, and taking action where a CCG has failed to exercise a function or not exercised a function properly (which may include non-compliance with National Tariff requirements). This will not be covered in the guidance. When the National Tariff comes into effect, Monitor will have powers to ensure commissioners comply with the National Tariff.

7 Next steps

Over the next few weeks we will be holding a number of workshops and webinars to solicit views on the matters covered by this document. In addition a web form is available at www.monitor.gov.uk/pricing for response to the questions posed in this engagement document. The deadline for receipt of responses to this engagement process is 5pm on Tuesday 9 July 2013.

We will continue develop the detailed analysis of our proposed National Tariff for 2014/15, incorporating information and views from this engagement process. We intend to publish the consultation notice on the proposed National Tariff in autumn 2013. Following publication there will be a 28 day period within which clinical commissioning groups and relevant providers can object to the proposed method for the determination of the national prices for mandated currencies. If objections satisfy the statutory thresholds to be set out in secondary legislation, we may re-consult on our proposed method, or refer the method to the Competition Commission. If having considered the responses to the consultation we decide to confirm the approach adopted in the consultation notice we would expect to issue the final NTD before the end of December 2013.

Table 7-1 Timetable

Date	Step
13 June 2013	Issue Engagement Document
July 2013	Regional Workshops and Webinars
9 July 2013	Deadline for responses to Engagement Document
autumn 2013	Issue statutory consultation notice
28 days after issue of notice	Deadline for responses to consultation notice
December 2013	Issue NTD*

* Issuing the NTD will be subject to any decision on whether to reconsult or make a reference to the Competition Commission in the light of objections or comments received.

7.1 Engagement questions

This section brings together all of the questions asked in this engagement document, including Appendix A: Impact Assessment. As explained in the Introduction we have divided the questions into two types:

- **General questions** that we expect all respondents will wish to answer in their engagement responses. These questions are numbered as Q1, Q2,...Q11; and
- **Detailed questions** relating to particular rules or areas of evidence on which we are seeking feedback. We hope to receive feedback from as many respondents as possible on these questions but recognise that some of these questions may not be relevant to some respondents. These Detailed questions are numbered DQ1, DQ2,...DQ22.

General questions

Section 3–Approach

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 tariff (using 2013/14 prices as the basis for adjustment)? Please give your reasons.

Q2. We are proposing to calculate the cost uplift to the 13/14 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?

Please give your reasons for these answers.

Q3. The purpose of the efficiency factor 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? Please give your reasons for this answer.

Q4. Do you agree with the methods that we propose to use to calculate 2014/15 prices? Please give your reasons.

Section 4 – Variations and Rules

Q5. Over the coming years, we intend to review all aspects on the rules set out under the Payment 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?

Q6. In developing the rules and oversight for local payment variations, a balance must be struck. We want to permit innovation in payment approaches to reflect new and better ways for care to be delivered. However, we need to ensure that risk is appropriately managed across the system and that we deter inappropriate behaviour. What suggestions do you have for how Monitor and NHS England can design the rules for local payment variations?

Section 5 - Local Modifications

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.

a) To what extent do you agree with these proposed criteria?
b) Are there any specific cases which would not be eligible for a local modification under these criteria but which you believe should be allowed?

Q8. Given the potential cross-subsidisation between different tariff services, Monitor is proposing to restrict local modification applications to cases where the provider cannot cease to provide the service and where the provider is in deficit on tariff services and at an organisational level. (These limitations do not apply to agreements).

To what extent do you agree with our outlined method to restrict eligibility for local modification applications?

Q9. The Health and Social Care Act requires Monitor to publish its methodology for deciding whether to approve local modifications.

a) What are your views on the proposed methodology for calculating local modifications?
b) Do you foresee any challenges with the implementation of this methodology?

Appendix A - Impact Assessment

Q10. 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 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?

Overall question

Q11. Do you have any further comments on the matters raised in this document?

Detailed questions

Detailed question on NTD

DQ1. What changes could be made to the proposed structure of the NTD and supporting documentation to make the material more accessible and the document easier to use?

Detailed questions on approach:

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? Please give reasons.

DQ3. Estimating the productivity gains achievable by providers is a complex task in light of the size, breadth and variety of NHS services. We have reviewed publicly available sources but we are aware that other evidence may be available.

Are you aware of / do you have additional evidence we should consider?

Detailed questions on Rules and Variations:

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?

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?

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; and
c) make further progress towards national prices.
Please give reasons for your answer.

DQ7. We have updated the lists of excluded high cost drugs and devices for 2014/15. We will consider a further update in September 2013 before Statutory Consultation. Do you have any comments on the additions and amendments to the excluded high cost drugs and devices lists?

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?

Detailed questions on Local Modifications

DQ9. What issues might arise if lead commissioners were to agree local modification agreements with providers on behalf of groups of commissioners?

DQ10. Monitor proposes to restrict local modifications applications to providers with a sustained and on-going deficit at an organisation level. Monitor is currently considering a range of options for the minimum level of deficit of between 2% and 5% of total revenues. What would you consider to be the appropriate minimum level of deficit for this purpose?

DQ11. What challenges might providers face in preparing the information required by Monitor, both with respect to the availability of data and the time and cost of providing the required evidence?

DQ12. What issues would providers face in determining the deficit/surplus at the individual HRG level and, in the case of applications, for tariff services overall and the provider overall?

DQ13. Is there any other relevant information which we should consider but which is unlikely to be taken into account under the approach proposed by Monitor?

DQ14. How might local modifications impact the incentives of providers and commissioners?

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 health care economy overall; or
c) cause any other unintended detrimental consequences?

Please give details.

Detailed questions on Impact Assessment

DQ16. Do you agree with the choice of the 2013/14 National Tariff as an alternative option to test the impacts of the changes proposed for the 2014/15 NTD? If you disagree, please indicate which other options we could consider the impacts against.

DQ17. Do you agree with the overall cost uplift and efficiency and specific impact areas identified (affordability, financial viability and quality)? Please identify any other impact areas we should consider.

DQ18. Do you agree with our assessment of the relevant specific impact tests for the autumn 2013 impact assessment? If you disagree, please describe what other areas we could consider, how we could assess the impacts and what data we would need.

DQ19. Do you agree with the proposed analysis to consider cost uplift and efficiency impacts for the autumn 2013 impact assessment?

DQ20. Is there additional evidence, data or information we could consider for the autumn 2013 impact assessment analysis of cost uplift and efficiency impacts? Please provide details.

DQ21. Do you agree with the approach described to assess the impact of specific price changes? If no, please suggest alternative approaches along with your rationale.

DQ22. Do you have suggestions for other assessment we could conduct in the autumn IA (or beyond)? If yes, please describe this assessment including a description of the data that would be required and whether you already collect and report this data.

Monitor: 4 Matthew Parker Street, London SW1H 9NP
Telephone: 020 7340 2400
Email: enquiries@monitor.gov.uk
Website: www.monitor.gov.uk

NHS England: PO Box 16738, Redditch, B97 9PT
Telephone: 0300 311 22 33
Email: england.contactus@nhs.net
Website: www.england.nhs.uk

Publication code: **IRCP 02/13**