Monitor
Making the health sector work for patients

NHS England

2015/16 National Tariff Payment System: Tariff engagement documents overview

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Summary

The National Tariff Payment System (the national tariff) covers national prices, national currencies, national variations, and the rules, principles and methods for local payment arrangements. Monitor and NHS England are currently in the process of setting the 2015/16 National Tariff Payment System (the 2015/16 national tariff). As part of this process, we began engagement with the publication of the 'National Prices Methodology Discussion paper' (the 'methodology paper') in April and subsequent engagement with the sector. The process continues with the publication of a set of tariff engagement documents that focus on our proposals for 2015/16.

This overview paper summarises our proposals; in particular the changes we are proposing to make across the national tariff compared to the '2014/15 National Tariff Payment System'. The proposals are set out in more detail in the other tariff engagement papers and we are seeking your views on those proposals. We believe that our proposals for the 2015/16 national tariff must be transparent, based on the best available evidence and effective consultation with the sector and impact assessed. To that end, as well as engaging on the proposals themselves, we have also published our framework for impact assessment.

Three key themes underpin the changes we are proposing for 2015/16:

- maintaining financial discipline while promoting high quality care in tough conditions
- encouraging transition to new payment designs at pace and scale
- strengthening the 'building blocks' of the national tariff.

We discuss each in turn below.

Maintaining financial discipline while promoting high quality care in tough conditions

The financial challenge facing both commissioners and providers in 2015/16 is expected to be significant. We want the national tariff to support the best outcomes for patients, while promoting an appropriate level of stability.

To ensure prices reflect efficient costs of providing NHS services and to drive achievable efficiency improvements we are proposing to set a single efficiency factor. We believe this factor should be in the range of 3–5%. This is based on analysis of data from acute providers and our expectation that next year will require an exceptional effort from all parts of the sector, including providers, to overcome the financial challenge. While we recognise that cost structures may be different across different parts of the sector, current data do not allow us to estimate such differences with sufficient accuracy. Most respondents to the methodology paper have told us that setting a single efficiency factor is a reasonable approach given the data

limitations, and we continue to propose that approach. A number of respondents did object or raise concerns, in particular some providers of mental health services who would be affected by the use of the efficiency factor (and cost uplifts) as the basis for negotiation of local prices. We are proposing that local price-setting should continue to have regard to the efficiency and cost uplift factors used for national prices. But we will engage with the sector on how the guidance we provide on this issue can be most helpful for ensuring local prices reflect efficient costs, promote quality improvements and suitably balance the allocation of financial risk between commissioners and providers.

We also want to ensure that prices are based on the appropriate costs and that we are not, for example, double-counting costs that are remunerated outside the national tariff. We are, therefore, interested in stakeholders' views on how to identify the appropriate cost level on which to set prices, including which costs, if any, are recovered through other non-tariff payment mechanisms or sources of revenue. We have identified a number of potential policy measures that could address 'tariff leakage' and are looking for feedback on this issue.

To support efficient, effective and economic delivery of services and high quality care we are proposing to introduce a best practice tariff for heart failure, and to move to more ambitious clinical thresholds for five existing best practice tariffs. We are also proposing to remove the national variations that are currently in place for maternity pathway payments, unbundled diagnostic imaging in outpatients, and chemotherapy delivery and external beam radiotherapy. Providers and commissioners have had two years to adapt and put appropriate mechanisms in place for these changes.

In our view, there is insufficient time to make other evidence-based changes to national variations. That means retaining the current Market Forces Factor and specialist services top-up arrangements, but we will be considering these, and other arrangements, in 2016/17 or beyond. Similarly, we will be considering the future need for the marginal rate rule and 30-day readmission rule as part of work on a new payment approach for urgent and emergency care. In the meantime, we will be working with commissioners and providers to ensure that the rules are applied in the best interest of patients.

We are also inviting the sector to provide feedback on two policy options we are considering, concerning payment for acute services without national prices, and the acceleration of the pace of convergence towards only remunerating efficient costs for specialised services. There are two options: either signposting existing commissioner-contracting options in guidance or using the 2015/16 national tariff to introduce a new local price-setting rule.

Encouraging transition to new payment designs at pace and scale

Shifting to new patterns of care is a priority if the sector is to achieve a long-term balance between growth in patient needs and expectations, and largely static budgets. This shift to new patterns of care is a significant challenge and will require everyone to rethink how care is delivered at all levels, with a common goal of meeting the needs of patients. It will require constructive engagement on innovative new approaches for delivering services. The payment system needs to adapt and support solutions to these new challenges.

The 2015/16 national tariff, while important in and of itself, is part of a longer-term shift in the payment system. So, in contrast to the emphasis on stability for 2014/15, we are proposing that the 2015/16 national tariff would contain policies that underpin moves towards new patterns of care. The national tariff should be a springboard to change. National prices need not be a default option to be invoked when service change or improvement is better for patients. The requirement in the local payment rules for commissioners and providers to engage constructively reflects a wider principle that should inform local negotiations – that all parties should make efforts to consider and accommodate payment arrangements that move away from national prices, where this enables service improvements that benefit patients.

We are proposing to provide the sector with opportunities to share experience and adopt new payment approaches, rather than mandating them before they have been thoroughly tested. We are proposing to offer examples of payment designs that are aligned to our emerging ideas on the long-term payment system redesign, which we want to see implemented by local health economies at pace and scale. The payment examples we are proposing to make available cover areas such as enabling person-centred co-ordinated care for those who are frail, elderly or have multiple long-term conditions, and testing a potential new payment approach (or approaches) to support implementation of recommendations stemming from the review of urgent and emergency care carried out by Sir Bruce Keogh.

Strengthening the ‘building blocks’ of the national tariff

We are proposing to update the currency design on which national prices are currently set to the currency design reflected in the 2011/12 Reference Cost collection, with adjustments that were included in the 2014/15 national tariff. We considered moving to the 2012/13 Reference Cost design (HRG4+) but such a move requires further extensive development, assessment and consultation with the sector before proposals can be worked up. This work can take place over the next 12 months and implementation may be considered for 2016/17. We are also proposing to introduce national prices for four services that were not priced in 2014/15, and to update how patients are grouped across maternity pathway currencies.

To ensure that national prices are as reflective of service costs as possible we are proposing to model them from updated costs, rather than applying a rollover as we did for 2014/15. We are proposing to base national prices on 2011/12 Reference Costs. We are also taking steps to improve the quality and transparency of the modelling by applying extensive data cleaning rules to the Reference Cost inputs, engaging with clinician expert working groups and our own National Tariff Advisory Group to identify any required adjustments to prices, and updating the short stay emergency tariff (SSEM) bands, which have remained unchanged since 2010/11.

We are proposing to retain the approach used in previous national tariffs for indexing Reference Costs up to the tariff year, and for estimating the cost uplift factor. We will engage with the sector on any service development costs associated with new requirements in NHS England's Mandate once details of the Mandate are known.

We are reiterating our commitment to the existing rules and principles for agreeing local payment arrangements, but are inviting stakeholder feedback on whether some may require changes in the interests of patients. We expect providers and commissioners to use the adult mental health cluster currency for payment, unless they develop an alternative approach in accordance with the applicable rules, and to submit Reference Costs data based on the clusters. In line with these rules, we also expect all local payment arrangements to be transparent and best meet patient needs. We also want to proceed with the development and adoption of new mental health currencies. We are proposing a local payment example for Improved Access to Psychological Therapies services, which has been developed and piloted for the past two years.

We are looking to enhance compliance with the national tariff through our work with the sector on local modifications, monitoring and tariff enforcement. For 2015/16, we are proposing to provide guidance on submitting local modification by 30 September 2015 , with a view in particular that lessons can be learned and best practice can be shared in time for the following year's commissioning rounds.

We are also proposing to make better use of information that is already collected by commissioners. We propose to provide guidance on the inclusion in local modification submissions of details of plans to address structural issues affecting the relevant services; and to require documents for local variations to identify how the patient benefits of the variation would be measured, and to identify any non-recurrent costs of redesigning and restructuring services.

Contents

1. Introduction

Monitor and NHS England are in the process of setting the 2015/16 National Tariff Payment System (the national tariff). As part of this process we are publishing a set of engagement documents (see Figure 1) to involve the sector in our decision-making ahead of issuing a statutory consultation notice in October. This paper provides an overview and summarises the changes we are proposing to make across the national tariff compared to the '2014/15 National Tariff Payment System'.

These engagement documents follow the 'National Prices Methodology Discussion paper' (the 'methodology paper') published in April and subsequent engagement with the sector. Where our proposals have been informed by feedback from this engagement, we have said so. The engagement documents focus on proposed changes and, therefore, do not set out the totality of the national tariff. We seek your views on the proposed changes and on our proposals that the other parts remain substantively unchanged, and will follow this publication with a series of webinars and workshops.

Alongside this paper we have published preliminary draft national prices and we are interested in your comments on them as well. These **prices are not final, and are only intended to illustrate the change in prices relative to one another, rather than their final levels**. For the purpose of consulting on the change in relative prices resulting from the proposed move to modelled prices,[1] we have adjusted prices from cost-reflective levels to those where the weighted average price equals that in 2014/15. The draft prices also do not include any cost adjustments (eg efficiency and cost uplift factors) as we do not yet have specific proposed values for them.[2] Any adjustments that ensure prices reflect only efficient costs will be included in the prices we publish with the statutory consultation notice.

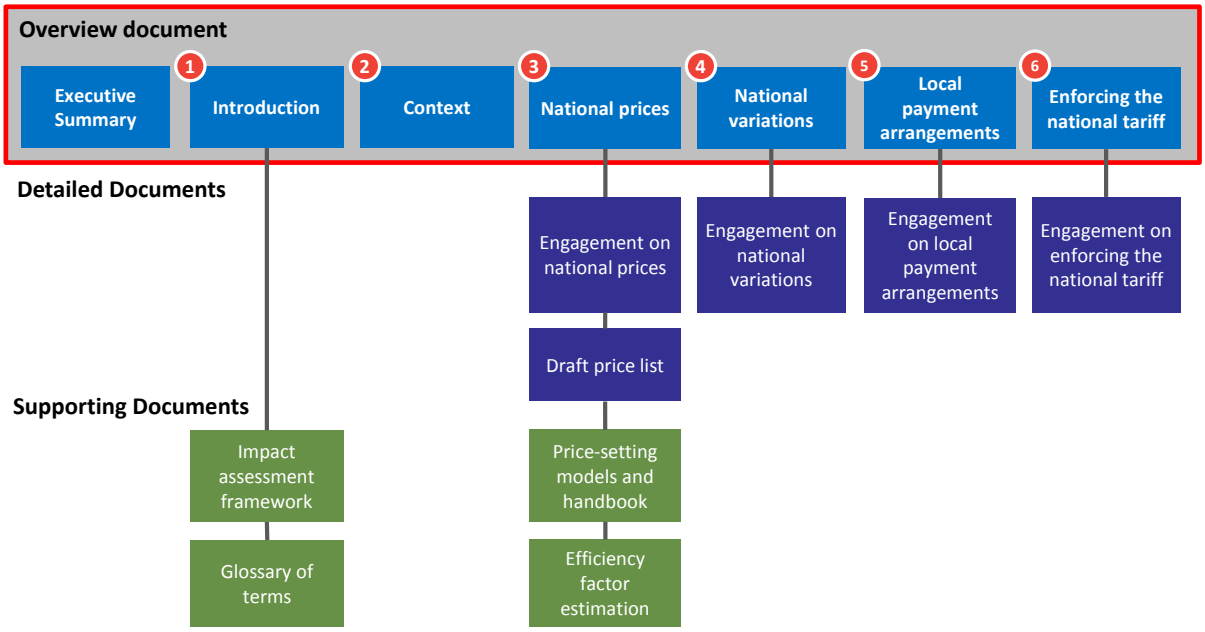
Additionally, we are proposing to publish a series of local payment examples, which we will be encouraging providers and commissioners to adopt in 2015/16. These examples illustrate some of the innovative payment approaches emerging in our work to develop the long-term design of the payment system. The rules on local price-setting require commissioners and providers to engage constructively and this should be reflected in a willingness to consider and, where appropriate, adopt new pricing mechanisms. We want to see widespread adoption of these methods, and so plan to provide support to providers and commissioners keen to test these new approaches, as well as developing mechanisms for feedback and evaluation. This will enable us to refine the designs for future national roll-out.

As part of our engagement on the 2015/16 national tariff, we encourage stakeholders to provide feedback on the potential impacts of our proposals on groups with

[1] Unlike 2014/15 national prices, which were based on a rollover of 2013/14 prices, we are proposing to move to a modelled approach for 2015/16.
[2] While we propose an efficiency factor range, we do not yet have a single value to apply to prices.

protected characteristics (as defined under the Equality Act 2010) or any other impacts that may affect patients, including any evidence relevant to identifying those impacts.

Figure 1: Map of 2015/16 National Tariff Payment System engagement documents



1.1 Process for making new proposals

The national tariff is the framework which governs the prices for NHS services. It includes prices, currencies, rules and methods that are intended to help commissioners work with providers (such as NHS trusts, foundation trusts and independent providers) to identify what mix of healthcare services provides best value to patients. We want our proposals to be informed by extensive engagement with the sector, including providers, commissioners, clinicians and other stakeholders. To that end, we have developed a staged engagement process for developing the proposals for the 2015/16 national tariff. The aim of this process is to ensure the health sector is engaged in the development of our proposals.

We hold our proposals to a high standard to ensure that the national tariff works in the best interest of patients. Our proposals must meet the following principles if they are to be appropriate and adopted by the sector:

- **Transparency:** We must be clear about our policy goals, the options we have considered to meet these goals, and our reasons for choosing between options when making proposals and decisions. This is an overarching principle, in that we must not only meet the remaining principles in this list but demonstrate transparently that we have done so.

- **Evidence-based:** Where we set out proposals in these engagement documents, we refer to evidence which supports those proposals. If we believe the evidence is lacking, we will say so, and we will be clear about the implications. This standard applies equally to policies developed by NHS England and Monitor, and to feedback we receive from stakeholders.
- **Effective sector engagement:** Stakeholders must have an opportunity to understand, assess and influence policy development. For some policy proposals, this might be achieved in a single step, but for more substantial policy change we might need to go through several iterations.
- **Impact assessment:** We have developed a consistent framework for assessing the impact of all policy proposals, informed by feedback on the draft framework published in April 2014. Where possible, we will use these impact assessments to inform our proposals, and include details in our stakeholder engagement processes. The framework for our impact assessments is published alongside this paper.

1.2 Structure of this document

The rest of this paper is structured as follows:

- Section 2 sets out the context for the 2015/16 National Tariff Payment System, including discussion of the longer-term direction of travel
- Section 3 summarises our proposals for national prices, including the proposed currencies, methodology for calculating prices, and adjustments for national prices
- Section 4 outlines our proposals for national variations
- Section 5 discusses our proposals for local payment arrangements
- Section 6 summarises Monitor's proposals in relation to enforcing the national tariff
- Annex A lists the questions on which we would like to hear stakeholders' views.

2. The 2015/16 national tariff in the context of long-term reform

Shifting to new patterns of care is a priority if the sector is to achieve a long-term balance between growth in patient expectations and largely static commissioning budgets. While we recognise this is a significant challenge, we think that it will raise levels of care quality and patient safety, with more patients receiving the right care, in the right setting, at the right time. There is a role for all of us in rethinking how care is delivered meet the needs of patients.

The payment system design needs to adapt to this changing environment. First, changes to the patterns of care will be reflected in funding flows, with focus on reducing the need for acute services by investing in community-based interventions and mental health services. We anticipate the financial impact of these changes will be different for each service; however, the payment system must enable such changes to funding flows. Second, the payment system itself can be a catalyst for service transformation. The specification of a unit of payment ('currency') and the approach used for determining a price – whether national or local – create incentives that affect productivity, accountability and care co-ordination. Our task over the longer term is to design a payment system that includes the right blend of tools and incentives to work best for patients. We plan to put forward further thinking on a long-term vision for the payment system design in the autumn.

So, in contrast to the emphasis on stability for 2014/15, we would like the 2015/16 national tariff to contain policies that will underpin shifting to new patterns of care. We are also seeking to strengthen the 'building blocks' of the payment system – through using better data; transparent assumptions, our methods and judgements; detailed impact analysis; and working closely with the sector. Our impact assessment framework provides a mechanism for understanding the likely impact of our proposals on commissioners, providers and patients. This includes potential impacts on integrated care, patient choice and equalities.

We have started work on a number of policy areas and are looking to make measured progress in our proposals for 2015/16. These policy areas include:

- Supporting integrated care pioneers and long-term conditions year of care sites. We want to help commissioners and providers understand and plan to implement the kind of capitated payments and sophisticated multilateral risk-sharing approaches that enable the co-ordination of care for people with multiple care needs or frailty factors. This can only be achieved when care organisational boundaries are bridged.

- Understanding the costs of providing urgent and emergency care services following the review by Sir Bruce Keogh, and the extent to which levels of payment should vary with activity levels and/or quality standards. We see a pressing need to reform payment structures for urgent and emergency care,

and want to explore how that could be done with a menu of options available for possible local adoption for 2015/16, to inform potential roll-out in 2016/17..

- Undertaking a stock take of opinions and evidence regarding mental health payment arrangements. This has identified consensus about the need to focus on improving data quality, integration of mental and physical health, tailoring care to individual needs, early intervention and recovery, and provision of care in the least restrictive settings.
- Investigating options for providing hospital-based planned care much more efficiently, through bringing about new ways of delivering outpatient services; enabling hospitals with excess capacity to provide extra operations at marginal cost to meet patient waiting-time targets; or accelerating convergence for specialised services at levels that reflect efficient costs.

Informed by the lessons learned from these projects, we are proposing to publish local payment examples that commissioners and providers can use with our support. We will also establish a programme to evaluate how well these examples work.

To have their intended effect, the signals sent by national prices and the rules for local payment arrangements must be credible. This means we need to use better data for national prices and local payment arrangements; and that the principles and rules we set out need to be applied . We have invested in thorough cleaning of cost data for our 2015/16 price calculations but a step change in costing precision is needed. So, Monitor has been working with the sector on developing a costing ‘road map’, to be published in the next few months. This sets out directions for improving costing systems significantly, in order to help the sector plan for investments and find efficiencies. The road map will lay down a vision for how patient-level costing meets the sector’s needs, and will set out proposals for transition plan.

A key mechanism to build credibility is through our work with the sector on local modifications, monitoring and tariff enforcement. In addition to reviewing the local modification and local variation submissions, we are investigating the implementation of last year’s changes to the urgent and emergency care marginal rate rule. Lessons learned will feed into future policy development and stronger guidance on how commissioners and providers should apply national tariff policies.

The need to reform the payment system is urgent, but so is the need to do this in a considered and systematic way. In developing the proposals summarised in this document we have been mindful of the need to promote stability in difficult circumstances while continuing to incentivise efficient provision of services. For 2015/16 we propose to provide the sector with opportunities to adopt promising new payment approaches, which we want to see adopted at pace and scale, and we will evaluate these with a view to possible wider roll-out in future years. We believe the 2015/16 national tariff will be an important step towards a ‘clean sheet redesign’ of the payment system.

3. National prices

National prices are a major part of the national tariff. Our core principles remain that national prices should reflect the efficient costs of care and send appropriate signals.

Setting national prices involves the following steps:

- NHS England leads on defining the currencies that have a national price
- Monitor leads on establishing the method for calculating the prices, including any adjustments to prices (to reflect, for example, cost inflation or expected efficiency gains).

At each step we work together to agree any proposed changes. The proposed currencies, methods and national prices set out in the statutory consultation which precedes publication of the national tariff must be agreed by both Monitor and NHS England.

This section summarises the changes we are proposing to make with regard to currencies and the calculation of national prices, including cost adjustments for 2015/16. The proposals are set out and discussed in more detail in the document ‘2015/16 National Tariff Payment System: Engagement on national prices’.

3.1 National currencies

Currencies are specifications of health services, used as the basis for payment for NHS services. For admitted patient care, the currencies used are Healthcare Resource Groups (HRGs), which group together diagnoses, treatments and care that may typically occur during a spell of care and use similar levels of resource. For 2015/16 we are proposing to make the following changes to national currencies:

- **Currency design:** We are proposing to update the currency design on which national prices are based to the 2011/12 Reference Cost design, with adjustments that were in the 2014/15 national tariff to resolve known issues with the design. This would ensure that national prices have a more up-to-date clinical basis. We considered moving to the 2012/13 Reference Cost design (HRG4+) but such a move requires further extensive development, assessment and consultation with the sector – since we only have one year’s worth of cost data collected using the HRG4+ design – before proposals can be worked up. This work can take place over the next 12 months and implementation of HRG4+ would be considered for 2016/17.
- **Introducing new national prices:** We have identified four services where the latest Reference Cost information allows us to set national prices where we did not set prices for 2014/15. We are proposing to introduce national prices for complex therapeutic endoscopy, dialysis for acute kidney injury, cochlear implants and transcatheter aortic valve implantation (TAVI).

- **New heart failure best practice tariff (BPT):** We think the payment system may be able to incentivise better outcomes for patients with heart failure by encouraging adherence to a number of processes identified as being associated with good care. We are proposing to introduce a BPT in which payment is linked to achievement of these care processes.

- **Changes to existing best practice tariffs:** We would like to incentivise delivery of high quality care by replacing transitional targets that are currently in place for some BPTs with more ambitious thresholds considered achievable by clinicians. We are proposing to amend the criteria for the following BPTs: hip and knee replacement, endoscopy procedures, day case procedures to manage female incontinence, tympanoplasty day case procedures and diagnostic hysteroscopy outpatient procedures.

- **Maternity pathway payment:** Stakeholders have suggested a number of potential improvements to the currencies used in the pathway payment, and raised a number of implementation issues. We reviewed the suggestions and for 2015/16 are proposing six additions to the factors used to allocate women to the correct antenatal pathway currencies. We will be issuing supplementary guidance to help providers address some of the implementation concerns. We are also exploring options for giving women more control and choice over how they access maternity services.

- **High cost drugs and devices:** We are proposing to update the list of high cost drugs and devices that are separately reimbursed (ie are not included in national prices) to ensure that it reflects current clinical practice. We are proposing to add 35 new drugs and one new device to the list.

3.2 Modelling national prices

In the methodology paper we expressed a preference for modelling prices from updated Reference Costs, rather than applying another ‘rollover’ as we did for 2014/15. This is because it is important to keep prices more up to date. Stakeholders largely supported our preference and, in light of this feedback, we are proposing to base 2015/16 national prices on updated Reference Costs. We are proposing to model national prices for 2015/16 by:

- **Using a model that builds on the Department of Health’s (DH) Payment by Results 2013/14 model:** It would be a significant and potentially risky task to develop a completely new model with the necessary sector engagement in the time available, and the DH model has been used for a number of years and is broadly understood by the sector. The majority of responses to the methodology paper supported this preference to improve the 2013/4 model, and considered it reasonable given current constraints.

- **Basing prices on 2011/12 Reference Costs:** Stakeholders were largely sceptical about the benefits of using an average of Reference Costs from several years, as we suggested in the methodology paper. Our own analysis has also indicated this approach appears to have limited benefits over using a single year of Reference Costs. Therefore, we are proposing to use one year's costs – the 2011/12 Reference Costs – as they most closely map to the proposed currency design for 2015/16.

- **Applying comprehensive data cleaning rules:** We believe that using cleaned data would improve both the accuracy of national prices and the transparency of the model. By removing implausible inputs into the model we should be able to reduce the need for manual adjustments to prices.

- **Quality assuring national prices:** We recognise that a number of modelled prices may need manual adjustment to correct for illogical relativities and implausible prices.[3] We would make any such adjustments transparently, and take into account recommendations by the Health and Social Care Information Centre's clinical expert working groups, and by Monitor and NHS England's National Tariff Advisory Group.

- **Updating the short stay emergency (SSEM) tariff bands:** In the methodology paper we set out three possible options for the SSEM tariff bands. These bands have not been updated since 2010/11. In light of stakeholder feedback, we are proposing to update both the method of calculation and the inputs into the SSEM band calculation. Additionally, we are proposing to update the currencies that are eligible for the SSEM tariff.

We are also interested in stakeholders' views on which costs, if any, should be 'netted off' from the Reference Costs on which prices are based (for example, if some costs are recovered elsewhere), and how to estimate that potential deduction. We want to ensure that the costs on which prices are based are indeed the appropriate basis for setting prices, and that we are not, for example, double-counting costs that are remunerated outside the national tariff.

3.3 Cost adjustments used in the calculation of national prices

Cost adjustments are percentage additions to or subtractions from the prices produced by our model. They reflect our expectations of increases or achievable reductions in the efficient costs of providing NHS services, which are not already captured in the model inputs since they pertain to years beyond the input data.

[3] Illogical relativities would be, for example, a higher price for an HRG without complications and comorbidities than for the corresponding HRG with complications and comorbidities. Implausible prices would be, for example, a national price that is lower than the cost of using the equipment involved in providing the service.

Specifically, we index costs up to the tariff year, and we make forecast adjustments for the tariff year. For 2015/16 we are proposing the following:

- **Use cost adjustments from past national tariffs for indexation:** We are proposing to use the efficiency and cost uplift factors from the national tariffs for the years in question to index 2011/12 Reference Costs up to the start of 2015/16. This is consistent with the approach previously used by the DH. While more up-to-date information may be available that would allow us to revisit some of those past factors, we think the benefits would be outweighed by the additional complexity and uncertainty that such an approach would introduce to the price-setting process.

- **Retain the approach to setting the cost uplift factors:** For 2014/15 we based the cost uplift factors on forecasts of the cost pressures NHS providers are expected to incur in the tariff year. These include input cost inflation (pay increases, drug costs and general inflation); changes in the cost of the Clinical Negligence Scheme for Trusts; changes in capital costs; and any additional costs expected to be incurred as a result of new requirements in NHS England's Mandate, where these costs can reasonably be expected to affect all providers ('service development'). We are proposing to retain this approach.

- **Introduce a consultative process for determining cost uplift linked to service development:** We will engage on any proposal for a service development uplift, as required, once the Mandate is published. We will ensure that we hear from a broad range of relevant stakeholders (including providers for all service types, commissioners and clinicians), and incorporate the information into any service development uplift included in the National Tariff document.

- **Efficiency factor:** While we think there may be different opportunities for future efficiency gains in different parts of the sector, the data currently available do not allow us to estimate these differences with sufficient accuracy. Estimates based on the last five years of available data from acute providers indicate that a range of 2–4% efficiency gains in a single year is supported by historical evidence. However, the financial challenges that the sector is expected to face in 2015/16 are particularly great. As a result, it may be reasonable to expect efficiency improvements across all parts of the sector to outpace historical trends. For providers, this would mean that efficiency gains may need to exceed historical estimates. Accordingly, we are proposing to set an efficiency factor within the range of 3–5% for 2015/16,

- **Leakage:** Following feedback to the methodology paper, we are defining leakage as the 'additional actions' that providers (or providers and commissioners) take to protect or improve a provider's financial position, other

than improving their efficiency. To ensure that value for money is achieved in the NHS; providers remain financially sustainable; and choice and competition are not stifled, it is important that we understand these additional actions well. We will be engaging further on this issue and on the policy measures we could take to address some of these actions (as appropriate). For the avoidance of doubt, if we decide to adjust national prices to take account of leakage (ie add a 'leakage factor'), we would not expect the adjustment to take the sum of the efficiency and leakage factors above the 5% identified as the top end of the range for 2015/16.

4. National variations

National variations reflect circumstances where it is appropriate to make national adjustments to national prices that apply in particular circumstances, as opposed to individual local variations agreed between a commissioner and their providers(s). For example, to reflect more precisely costs that are not fully captured in national prices or to share risk more appropriately between providers and commissioners. This section summarises our proposals regarding national variations for 2015/16. The proposals are set out and discussed in more detail in the document '2015/16 National Tariff Payment System: Engagement on national variations'.

For 2015/16 we are proposing to remove the national variations that are currently in place for:

- maternity pathway payments
- unbundled diagnostic imaging in outpatients
- chemotherapy delivery and external beam radiotherapy.

This is because providers and commissioners have had two years to adapt to the above changes and put appropriate mechanisms in place, and it is reasonable to expect all providers to have adopted the standard practices by now.

In developing the '2014/15 National Tariff Payment System' and in developing our proposals for 2015/16, we have heard from stakeholders about changes they would like to see to national variations (see examples below). To make these changes in an evidenced way will take more than the time available this year, and so we do not propose to make changes to national variations for 2015/16 beyond those described above. We continue to work towards further changes in 2016/17 and beyond.

For example, we are working with the University of York to review specialised top-ups. As part of this work we are looking at the drivers of cost in hospital-based services and, in particular, whether there are additional costs for complex patients not currently reflected in national prices. For example, there is some evidence that providers with a higher proportion of specialised services enjoy a stronger financial position.[4] We recognise, however, that patient characteristics are just one feature of costs and over time we may look at others, such as geographical features. Some of these may already be reflected in the Market Forces Factor. We will be engaging with stakeholders on this work.

Similarly, as part of work on a new payment approach to support reforms to urgent and emergency care, we will be considering the future need for the marginal rate rule and 30-day readmission rule. This could begin to affect the 2016/17 national tariff,

[4] Monitor, 'Performance of the foundation trust sector: year ended 31 March 2014'.

and so we are proposing to retain the existing rules for 2015/16. In the meantime, we will be looking to work with commissioners and providers to ensure that the rules are applied in the best interest of patients. This will involve considering whether additional guidance is required on setting local baselines; where to find more information about effective admissions avoidance schemes; and whether further enforcement action is necessary to ensure adherence to the existing requirements.

However, depending on the final modelled prices and impact assessment, we may propose adjustments to national variations for 2015/16, where these would be in the best interests of patients. This could include proposing adjustments to top-ups, if changes to the currency design and updates to the cost base mean that current variations are no longer appropriate.

5. Local payment arrangements

Many prices for NHS services are determined locally rather than nationally. In the '2014/15 National Tariff Payment System' we set out the requirements that apply to the three types of 'local payment arrangements':

- local modifications to a national price
- local variations to a national price
- local prices where services do not have national prices.

This section summarises our proposals regarding local payment arrangements for 2015/16. The proposals are set out and discussed in more detail in the document '2015/16 National Tariff Payment System: Engagement on local payment arrangements'.

We want our proposals for 2015/16 to signal a real push towards innovation in local pricing. We want to create room to innovate, and gather evidence and learning from the sector, with a view to adopting some successful approaches for national roll-out in future years. We, therefore, want to see the local payment examples that we are providing implemented at pace and scale, with our support and with a quick and easy feedback loop. We want to move away from a position where innovation can be stifled by a commissioner or provider that is unwilling to engage.

For 2015/16, we are proposing the following:

- **Payment rules for mental health services:** We want to ensure local payment approaches enable a person-centred approach to care and parity between physical and mental health. We expect payment for mental health services to comply with the principles for local payment arrangements (transparency, best interest of patients and constructive engagement). We do not believe this can be done through simple block contracts. We propose to confirm existing rules for determining local prices for mental health services, including the requirement to report on the basis of care clusters. We will also develop supplementary guidance to help providers and commissioners move to payment models that better support the above expectations.
- **Supporting innovation by providing examples of payment designs:** As our long-term reform of the payment system is ongoing, we propose to support providers and commissioners in using the existing principles and rules for local payment arrangements by providing examples of payment designs that are aligned to Monitor and NHS England's emerging ideas for the payment system in the long term.
- **Setting prices that reflect the efficient cost of provision:** While we recognise that cost structures may be different across different parts of the

sector, the data currently available do not allow us to estimate such differences with sufficient accuracy. We propose to retain the rule that local price-setting should have regard to the efficiency and cost uplift factors used for national prices. We want to engage with stakeholders on how the guidance we provide in this area can be most helpful to ensure local negotiations result in price changes that reflect efficient costs, promote quality improvements, and suitably balance the allocation of financial risk. To ensure that local prices are set at the optimum level, commissioners and providers will want to review them thoroughly rather than simply rolling them forward, with an adjustment, each year.

- **Promoting value in acute services without national prices:** We are inviting the sector to provide feedback on two policy options we are considering. that are aimed at promoting value for patients from payment for acute services without national prices,[5] and at accelerating the pace of convergence towards only remunerating efficient costs for specialised services. The options represent two alternative policy responses: either signposting existing commissioner-contracting options in guidance or using the 2015/16 national tariff to introduce a new local price-setting rule.

[5] This includes services commissioned by NHS England or by clinical commissioning groups (CCGs) from acute providers of acute physical health care services (ie it does not include community, mental health and transport services). Commissioning for Quality and Innovation (CQUIN) payments, and reimbursement of high cost drugs, devices and procedures would also be excluded.

6. Enforcement and local modification casework

Monitor's powers to enforce the national tariff remain unchanged in 2015/16, and the system for handling local modification cases will be largely unchanged. Monitor's approach to enforcement and compliance will be informed by the lessons learnt during 2014/15 and by responses to the proposals in this paper. This section summarises our proposals regarding tariff enforcement and local modification casework for 2015/16. A fuller discussion of the proposals is provided in the document '2015/16 National Tariff Payment System: Engagement on enforcing the national tariff'.

For 2015/16, Monitor is proposing to publish guidance on:

- **Submission of local modifications by 30 September 2015:** Adoption of this guidance would allow Monitor to evaluate the majority of local modifications in time to share lessons learned to inform the following year's commissioning rounds.
- **Inclusion of plans to address structural issues in submissions of local modifications:** Monitor is proposing that submissions of local modifications for 2015/16 should identify how commissioners and providers plan to address their structural issues through Strategic Commissioning Plans and provider business plans. This information will be shared with the sector as part of our lessons learned, except for commercially confidential information.
- **Publishing on Monitor's website decisions on local modifications:** In response to requests from stakeholders to improve transparency on all decisions, Monitor is proposing to publish decisions on local modifications, whether or not they are approved.
- **Identification of how benefits of the arrangements will be measured for local variations:** Commissioners are currently not required to demonstrate how they will measure the benefits that their local variations are intended to achieve. This limits our ability to assess compliance with the rules for local payment arrangements and to identify and share innovation and good practice with the sector. For 2015/16, Monitor is proposing that these measures should be identified in local variation submissions.
- **Identification of costs incurred due to service change for local variations:** In circumstances where a local variation results in a higher agreed price than would be implied by national prices (for example due to service redesign costs), Monitor is proposing that the 'change cost component' should be separately identified in documentation submitted.

Annex A: Questions for engagement

We want to hear from you about the issues raised in this paper and the supporting documents. In particular we would welcome your response to the questions set out below. To ensure that your feedback is accurately captured, we encourage you to respond using our online response form. If you do not wish to use the form or are unable to do so, you can send your feedback to: paymentsystem@monitor.gov.uk. For comments on the draft national prices, please use the Excel response form.

The deadline for responses is **midday** on **Friday 15 August 2014**. While we will endeavour to consider all responses, regardless of when they are submitted, we cannot guarantee that we will be able to take account of responses received after the deadline in time for the statutory consultation notice.

Unless marked confidential, we intend to publish the responses on our website. If you would like your name or the name of your organisation to be kept confidential and excluded from the published responses, please make this clear in your response.

If you would like any part of your response – instead of or as well as your identity – to be kept confidential, please let us know and make it obvious by marking in your response which parts we should keep confidential. An automatic computer-generated confidentiality statement will not count for this purpose. As a public body subject to Freedom of Information Act, Monitor cannot guarantee that we will not be obliged to release it subsequently, even if marked confidential.

When answering the questions below, please also consider what impact (positive or negative) the policy will have on patients, in particular those with protected characteristics.

Questions on national prices

National currencies

1. Do you agree with our proposal to introduce new national prices for:
    a. complex therapeutic endoscopy?
    b. dialysis for acute kidney injury?
    c. cochlear implants?
    d. transcatheter aortic valve implantation (TAVI)?

2. Do you agree with our proposal to introduce a new best practice tariff for heart failure that is based on one or more care processes?
3. Do you agree with our proposal to move to more ambitious thresholds on the best practice tariffs for:
    a. hip and knee replacement?
    b. endoscopy procedures?
    c. operations to manage female incontinence day case procedures?
    d. tympanoplasty day case procedures?
    e. diagnostic hysteroscopy outpatient procedures?
4. Do you agree with our proposal to add six factors to the maternity pathway currency, to improve allocations?
5. Do you agree with our proposed additions to the high cost drugs list?

Price-setting model

6. Do you have any views on how we should identify the appropriate cost level on which to set prices; including which costs, if any, should be stripped out of the Reference Costs used to model national prices?
7. Do you have any comments on the proposed data cleaning rules, and the proposed process for manual adjustments to modelled national prices?
8. Do you agree with our proposed changes to the SSEM bands and eligibility?

Cost adjustments for national prices

9. Do you agree with our proposals to retain the previously used approaches for indexing costs up to the tariff year, and for setting the cost uplift factor?
10. Do you agree with our proposed process for coming up with any service development uplift?
11. Bearing in mind our proposed range of 3–5%, what do you think the efficiency factor applied to national prices in 2015/16 should be?
12. What do you think are the appropriate policy measures to address any undesirable ‘additional actions’ that are potential sources of leakage?

Questions on national variations

13. Do you agree with our proposal to remove the national variation for the maternity pathway payment?

14. Do you agree with our proposal to remove the national variation for the unbundled diagnostic imaging in outpatients?

15. Do you agree with our proposal to remove the national variation for chemotherapy delivery and external beam radiotherapy?

Questions on local payment arrangements

Mental health services

16. Do you think our proposed guidance on applying the rules will sufficiently clarify for commissioners and providers how to develop local payment arrangements for mental health services?

Local payment design examples

17. Would the planned topics and content of the proposed payment examples help you to make more effective use of local payment arrangements to support the changes you are planning to make to respond to the short-term and long-term challenges?

18. What benefits and costs do you see from making the approaches used in the payment examples the default national payment approach potentially from 2016/17?

Setting and adjusting local prices to reflect efficient costs

19. How can we strengthen the guidance to support local negotiations so as to ensure that local prices reflect efficient costs?

Promoting value in acute services without national prices

20. How well would each of the options achieve the policy goal of promoting value for patients from payments for services without national prices and accelerating convergence to prices that reflect most efficient costs? What issues would need to be considered in implementing each option?

Questions on enforcing the national tariff

Reporting requirements

21. Do you agree with our proposed guidance on the submission of information in relation to local payment arrangements? Specifically:

    a. on a proposed date for submitting local modifications to Monitor

    b. on the inclusion in local modification submissions of details of plans to address structural issues

    c. for publishing decisions to refuse local modifications, as well as approvals and

    d. for the inclusion in local variation submissions of information relating to measuring the benefits of the variation and on non-recurrent costs of redesigning and restructuring services

    e. on recording information about local pricing

22. Do you think that any of the proposed changes in question 21(a) and (b) should by made mandatory by a change to the method for local payments, rather than being set out as guidance?

General questions

23. Do you think that any of the proposals in the engagement documents (individually or collectively) will have an impact (whether positive or adverse) on persons with ‘protected characteristics’ under the Equality Act 2010? If there is any potential adverse impact, how might it be mitigated?

24. Do you foresee any information governance issues arising from the proposals in this document?

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