Monitor
Making the health sector work for patients

NHS England

2016/17 national tariff proposals: National variations and locally determined prices

www.gov.uk/monitor

Background to proposals for the 2016/17 national tariff

Monitor and NHS England use the national tariff to set national prices and to establish the rules that commissioners and providers must use to agree locally determined prices. Last December, in *Reforming the payment system for NHS services: Supporting the Five Year Forward View*[1] we set out how we intend to encourage:

> **Continuous quality improvement.** The payment system needs to promote the long-term, sustainable well-being of the whole person by reimbursing providers for delivering specified quality outcomes for patients rather than particular treatments or inputs.
>
> **Sustainable service delivery.** The payment system needs to incentivise best practice efficient and accessible delivery of care, to make sure that NHS funding goes as far as it can for patients.
>
> **Appropriate allocation and management of risk.** The payment system can help to make sure that financial risks in the NHS, caused by demand pressures or operational performance, sit with those organisations, whether commissioners or providers, that are best able to influence or absorb them in the context in which they arise.

Our proposals for 2016/17 support these objectives. In setting the national tariff, we also aim to improve the payment system to make it more transparent, to reflect latest information and to improve the method by which prices are set.

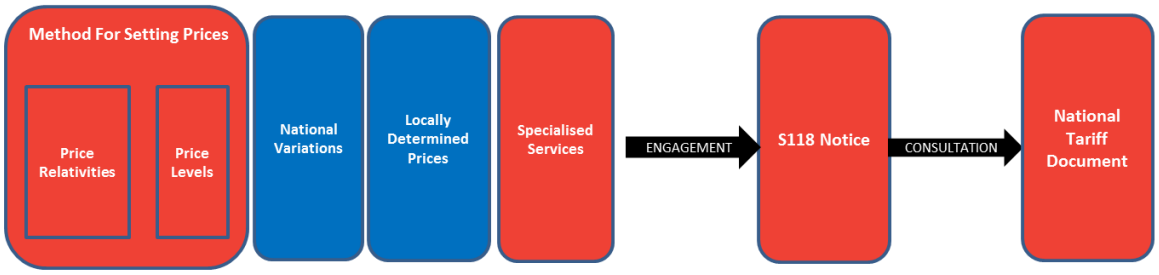
We have already engaged with many stakeholders in developing our proposals for 2016/17. However, we are also changing the way we engage with the sector on the 2016/17 tariff. Specifically, we are engaging separately with the sector on issues surrounding reimbursement for specialised services. We are also waiting on the outcome of the forthcoming Government Spending Review before finalising proposals on the efficiency factor, cost base and service development, which will help us to set final price levels. We therefore do not intend to engage on these elements over the summer.

About this document

This document is the second in a series seeking feedback from all interested parties on our proposals for the 2016/17 National Tariff Payment System. In it we explain our proposed changes to the rules concerning national variations, the rules for locally determined prices and the method for determining applications for local modifications.

---

[1] Available from: www.england.nhs.uk/wp-content/uploads/2014/12/reforming-payment-system.pdf



We are required to start from the tariff currently in force, the 2014/15 national tariff. The most significant change we propose in this document is to increase the rate at which emergency admissions above an agreed baseline are reimbursed, from 30% to 70%. We also propose to remove three national variations and make two adjustments to the rules for locally determined prices.

We have listened to your feedback on our previous consultations and changed this document to make the language, and the logic behind our proposals, clearer. You can comment on our proposals via an online survey.

Contents

1. Introduction

1. This is the second engagement document on policies proposed for the 2016/17 National Tariff Payment System (NTPS). In this document, we propose changes to national variations, the rules and guidance for locally determined prices and the method for granting local modification applications.

2. Unless otherwise identified we propose to retain the approach adopted in the 2014/15 NTPS.

3. We begin by outlining the context and scope of this document. Following chapters are dedicated to specific proposals. We provide an overview of each proposal and the evidence that has informed the proposal.

4. We have asked questions in relation to each proposed policy change. More details on the questions, and how you can respond, are at the end of this consultation document.

5. We may bring forward further proposals in relation to mental health payments, including potential changes to the rules, in the light of the recommendations of the mental health task force.

6. Monitor will include a full assessment of the likely impact of these proposals if they are included (as modified in light of the current engagement) in the 2016/17 national tariff statutory consultation notice. For the proposals in this document, we have included a preliminary assessment of the impact of the change to the marginal rate rule in Annex 1. We encourage stakeholders to provide feedback on the potential impact of the other proposals we have made. In particular, we welcome feedback on the potential impact on groups with protected characteristics under the Equality Act 2010, or any other impact that may affect patients, along with evidence to help identify those impacts.

7. Please respond using our online survey.[2]

[2] Available at: www.research.net/r/CXPNFLS

2. Context

Summary

The NHS faces significant financial challenges and the way that healthcare is provided must change. The payment system can help support these changes by reimbursing efficiently incurred costs, incentivising behaviour change and aligning payment to new models of care. There are cases where national prices do not achieve the aims of the payment system. In such cases, national variations and local pricing rules and principles have been developed to give flexibility within the system while retaining transparency and accountability.

8. The national tariff covers £72 billion of healthcare spend, through national prices – which account for £31 billion – and rules governing locally set prices. It seeks to reimburse providers of healthcare services for efficiently incurred costs and to incentivise desired behaviour (such as adoption of clinical best practice). It also provides crucial information on the efficient costs of providing services that can be used to improve commissioning choices and service delivery.

9. To address the financial challenges facing the NHS, the way that healthcare is provided must change and the payment system must support this. Monitor and NHS England, along with our national partners, outlined new models of care in the Five Year Forward View to discuss how care might be provided in the future. We followed this up with a document discussing implications for payments: *Reforming the payment system for NHS services: supporting the Five Year Forward View*.

10. Where national prices do not achieve the aims of the payment system, for example, due to local conditions or unintended consequences, national or local variations can be used to adjust national prices. If national prices do not reimburse providers for efficiently incurred costs, providers can seek a local modification to increase the price they receive.

11. This document explains our proposed changes to national variations, the guidance and rules for locally determined prices and the method for granting local modification applications, for the 2016/17 NTPS.

12. Proposed changes to national variations for specialised services are not covered in this document.

3. Scope

Summary

This document covers only those policies on national variations and locally determined prices where we propose to make changes to the approach adopted in the 2014/15 NTPS.

13. In developing our proposals we have considered:
    a. feedback on the 2015/16 statutory consultation notice
    b. policies and processes set out in the 2014/15 NTPS
    c. feedback from the sector about the complexity of pricing policy
    d. changes that we propose to make, including
        i. changes that were proposed for 2015/16 but were not implemented following the rejection of the 2015/16 statutory consultation notice
        ii. further changes that we wish to include in 2016/17.
14. This document does not cover:
    a. Content and policies from the 2014/15 NTPS that we do not currently propose to change.
    b. Proposals to change:
        i. currency design for national prices
        ii. the method for determining national prices
        iii. policy that specifically relates to provision and payment of specialised services
    c. Changes that are proposed to supporting guidance for the 2016/17 NTPS. We will engage on these during their development and consult on any changes in due course.

4. National variations

Summary

This chapter explains our proposals on:

- the marginal rate emergency rule
- the removal of three of the national variations designed to share financial risk following (or during) a move to new payment approaches.

We do not propose to make any changes this year on:

- the market forces factor
- emergency readmissions within 30 days
- the national variation to support implementation of the best practice tariff (BPT) for primary hip and knee replacements.

This chapter does not cover proposals to change national variations for specialist services.

15. National variations are variations to national prices set out in the national tariff.[3] They address circumstances where it is appropriate to make national variations to national prices (as distinct from local variations agreed between commissioners and providers). National variations may reflect certain features of costs that are not fully captured in national prices or seek to share risk more appropriately between providers and commissioners. The national variations in the 2014/15 NTPS aim to do one of the following:

    a. improve the extent to which prices reflect location-specific costs (eg the market forces factor)

    b. improve the extent to which prices reflect patient complexity (eg specialist top-ups)

    c. create incentives to share responsibility for preventing avoidable unplanned hospital stays (eg the marginal rate emergency rule)

    d. share financial risk appropriately following (or during) a move to new payment approaches (eg national variation to support the implementation of the BPT for hip and knee replacements).

16. This chapter explains our proposed changes to the following national variations in 2016/17:

[3] See Section 116(4)(a) of the Health and Social Care Act 2012.

a. the marginal rate emergency rule

b. three of the four existing national variations designed to share financial risk following (or during) a move to new payment approaches.

4.1. Marginal rate emergency rule

Summary

We propose to retain the national variation under which emergency admissions above the agreed baseline value are not reimbursed at 100% of the national price. We propose that the rate of reimbursement for these admissions is changed from 30% to 70%.

This change would also recognise the efforts providers have made to manage the pressures of rising number of emergency admissions and help address some of the financial challenges for smaller providers where emergency admissions are a significant share of their activity.

4.1.1. Context

17. The marginal rate emergency rule was introduced in 2010/11 in response to increases in emergency admissions in England that could not be explained by population growth and growth in A&E attendances. The growth in emergency admissions was primarily made up of emergency spells lasting less than 48 hours.

18. The marginal rate rule is intended to encourage:

    a. lower rates of emergency admissions

    b. acute providers to work with other parties in the local health economy to reduce the demand for emergency care.

19. The marginal rate rule sets a baseline monetary value (specified in pound sterling) for emergency admissions at a provider. A provider is then paid a percentage (30% under the 2014/15 NTPS) of the national price for any increases in the value of emergency admissions above this baseline. Overall, commissioners must set aside sufficient budget to pay for 100% of emergency admissions. Commissioners are then required to spend the retained percentage on managing local demand for emergency care.

20. As part of the development of proposals for the 2014/15 NTPS, Monitor and NHS England reviewed evidence relating to emergency care and the marginal rate rule. We received feedback suggesting that in some cases, the rule has encouraged more co-ordinated management of demand for emergency care and of discharges back into the community.

21. While the original design of the marginal rate rule set a national baseline expectation, our review of the policy in 2014/15 identified that in some localities, change is needed to ensure the policy works more effectively. For example, where there have been major changes to the pattern of emergency care in a

local health economy, or where there has been insufficient progress towards demand management and discharge management schemes. In 2014/15 we therefore updated the marginal rate rule to:

a. require baseline adjustment where necessary to account for significant changes in the pattern of emergency admissions faced by providers in some localities

b. ensure retained funds from the application of the rule are invested transparently and effectively in appropriate demand management and improved discharge schemes.

4.1.2. Proposal

22. In the 2015/16 statutory consultation notice we proposed to change the marginal rate rule so that providers were paid 50% of the national price rather than 30%. For 2016/17, we propose to change the marginal rate rule so that providers are paid 70% of the national price for any increases in the value of emergency admissions above the baseline. This approach has already been adopted by providers who have accepted the 'Enhanced Tariff Offer' (ETO) in 2015/16.[4]

4.1.3. Rationale

23. We have proposed this change in recognition of the efforts that providers have made to manage the pressures of rising numbers of emergency admissions. Our proposal for 2016/17 builds on the approach set out in the 2015/16 statutory consultation to ensure that financial risks are shared appropriately between providers and commissioners. This will also help to address some of the financial challenges for smaller providers where emergency admissions are a significant share of their activity.

24. We will make a judgement on whether to include this particular proposal in the final proposals for statutory consultation alongside other decisions on marginal rates in specialised services. We will engage separately on proposals for marginal rates in specialised services prior to the statutory consultation.

25. We will consider the need for the marginal rate rule in future as part of our work on a new payment approach for urgent and emergency care. This new payment approach will not be ready for use in 2016/17. Therefore, we believe it appropriate that the marginal rate rule remains in place.

[4] Available at: www.england.nhs.uk/resources/pay-syst/tariff-guide/

26. We set the level at 70% for the ETO to recognise the financial challenges that face acute trusts, particularly smaller trusts, while recognising the benefits of maintaining some incentive to manage demand for emergency care.

4.1.4. Options considered

27. Moving to 50% reimbursement: We considered and rejected this option after taking into account the pressures on providers of rising numbers of emergency admissions and the financial challenges for smaller providers. Some responses to the 2015/16 consultation argued that a move to 50% reimbursement would not be sufficient to resolve the difficulties caused to providers by the 30% rate.

28. Removing the marginal rate rule: We considered and rejected this option as a new payment approach for urgent and emergency care is not being introduced for 2016/17, and we do not want to remove the incentive that the rule creates for providers and commissioners to work together to reduce the demand for emergency care.

4.2. Removing transitional national variations

Summary

We propose to remove the transitional national variations for:

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

These were introduced to allow the sector to adapt to new payment approaches. The sector has now had three years to adapt to these changes. We therefore propose that the transitional measures are removed in 2016/17.

4.2.1. Context

29. In 2013/14 national variations were introduced in several areas to support transition to new payment approaches and to mitigate any adverse effects in the early stages of implementation. These included:

    a. Maternity pathway:

        i. Maternity pathway payments were introduced, along with a requirement for providers to collect the data itemised in the Maternity Services Data Set.

        ii. A national variation to share financial gain and loss between providers and commissioners was put in place for 2013/14 and 2014/15 to offset the impact of moving to pathway payments.

    b. Outpatient diagnostic imaging:

        i. Separate prices were set for diagnostic imaging undertaken as part of outpatient attendances.

        ii. A national variation was established to mitigate the financial risks that could result from the ‘unbundling’ of the cost of this activity from national prices. The variation set a marginal rate of 50% of the national price for any activity that was above trend growth, and allowed providers and commissioners to share the financial gains and losses resulting from unbundling.

    c. Chemotherapy delivery and external beam radiotherapy:

        i. Mandatory currencies for chemotherapy delivery and external beam radiotherapy were introduced in 2012/13 and national prices were introduced for these currencies in 2013/14.

ii. In that year, commissioners and providers were expected to move at least half way from local prices to national prices. In 2014/15 all providers and commissioners were required to use national prices unless doing so would have an unmanageable financial effect on either provider or commissioner.

4.2.2. Proposal

30. We propose to remove the national variations for the maternity pathway payment, outpatient diagnostic imaging services, and chemotherapy delivery and external beam radiotherapy. Providers and commissioners would be expected to adopt the appropriate payment arrangements and prices. These changes were previously proposed in the 2015/16 statutory consultation notice.

31. Where providers or commissioners consider that moving to national prices and payment arrangements would have an unmanageable effect on their finances and, as a result, pose a risk to patient care, they may want to consider seeking agreement on a local variation.

4.2.3. Rationale

32. The national variations for the maternity pathway, outpatient diagnostic imaging, and chemotherapy delivery and external beam radiotherapy were introduced for a limited period of time to support providers and commissioners to move to national prices and new payment arrangements. We believe that it is now appropriate to remove the national variations. Extending these further would reduce the impact of the payment changes.

33. Responses from the sector to the 2015/16 tariff engagement document showed support for removing the national variations for the maternity pathway payment and outpatient diagnostic imaging.

34. However, some of the feedback from the sector expressed concern that removing the national variation for chemotherapy delivery and external beam radiotherapy would have an unmanageable impact on the finances of particular providers and commissioners. We believe that this is most appropriately managed at a local level using local variations.

4.2.4. Options considered

35. We considered not removing these national variations but we felt that this would undermine the changes to prices and the payment system that had been made in previous years.

5. Locally determined prices

Summary

For 2016/17 we propose to make the following changes to locally determined prices:

- introduce statutory guidance to support rules 1 and 2 for services without a national price
- introduce a date for the submission of local variations
- introduce a date for the submission of local modification applications.

36. Approximately £72 billion of NHS activity is covered by the national tariff. This is made up of specialised services commissioned by NHS England and secondary, community, mental health and ambulance services commissioned by clinical commissioning groups. Approximately £31 billion of this spend is covered by national prices. The remaining £41 billion is covered by local pricing arrangements.

37. National prices can be adjusted locally when it is in the best interests of patients (local variations) or where they do not adequately reimburse efficient costs because of unavoidable structural issues (local modifications). These changes must be published and, in the case of local modifications, Monitor must agree to the proposals.

38. Where there is a nationally determined currency but no national price, providers must submit a local price template to Monitor. These prices are used by Monitor and NHS England to develop pricing policy.

5.1. Introducing guidance on setting local prices for services where there is no national price

Summary

We propose to introduce guidance on the rules for setting local prices for services that do not have a national price. This policy proposal is very similar to one that we set out in the 2015/16 statutory consultation notice.

5.1.1. Context

39. In the 2015/16 statutory consultation notice, we proposed guidance[5] on the application of general rules 1 and 2 for all services without a national price in the 2014/15 NTPS.

    a. Rule 1 states that providers and commissioners must apply the principles for locally determined prices when agreeing prices for services without a national price.

    b. Rule 2 states that commissioners and providers should have regard to the national tariff efficiency and cost uplift factors when setting local prices for services without a national price.[6]

40. Since the 2014/15 NTPS, we have received feedback from commissioners and providers that it would be useful to have clarification on these rules.

5.1.2. Proposal

41. The guidance that we propose to include in the 2016/17 NTPS is:

    a. "Where prices are determined locally, it is the responsibility of commissioners to negotiate and agree prices having regard to relevant factors, including opportunities for efficiency and the actual costs incurred by their providers. When adjusting prices agreed in previous years, commissioners and providers may agree to make price adjustments that differ from the adjustments for national prices where there are good reasons to do so. In addition, commissioners should ensure that local prices are in the best interests of patients, that there is transparency and that they engage constructively when setting local prices, in accordance with the principles referenced in Rule 1.

---

[5] See page 193 of *National Tariff Payment System 2015/16: a consultation notice* at https://www.gov.uk/government/consultations/national-tariff-payment-system-201516-a-consultation-notice

[6] See page 151 of *2014/15 National Tariff Payment System* at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/300547/2014-15_National_Tariff_Payment_System_-Revised_26_Feb_14.pdf

b. These principles apply to both whole year agreements and any adjustments to prices during the course of the year. Monitor will consider taking compliance action, under its enforcement policy, where there is evidence of non-compliance with the rules in this section. For further details see Monitor's guidance on *Enforcement of the National Tariff*.[7]

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

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

   i. commissioners agreeing to fund service development improvements

   ii. additional costs being incurred as part of service transformation

   iii. taking account of historic efficiencies achieved (eg where there has been a comprehensive service redesign)

   iv. comparative information (eg benchmarking) about provider costs and opportunities for efficiency gains

   v. additional funding for specific purposes as it is made available (for example, in 2015/16 NHS England has made available additional funding to support improved access to early intervention care for psychosis)."

5.1.3. Rationale

42. The current proposals are based on those set out in 2015/16. We have made these proposals again for 2016/17 following further questions from commissioners seeking clarity on the intentions and application of the rules.

[7] Available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/300865/Enforcement_of_the_national_tariff.pdf

5.2. Local variations

Summary

We propose to amend the rules on local variations to include a deadline of 30 June of each year for commissioners to submit templates to Monitor, where the local variation is included in a new commissioning contract for the year. Where commissioners and providers subsequently agree a local variation during the term of the contract, the local variation template should be submitted within 30 days of the change being agreed.

The aim is to improve transparency of commissioners' written statements on local variations (as required under s116(3) of the 2012 Act) and to increase Monitor's ability to ensure compliance with the national tariff.

5.2.1. Context

43. Local variations are an adjustment to a nationally priced service, or a nationally mandated currency.

44. Currently, commissioners are requested to submit local variations to Monitor within 30 days of signing a contract (or 30 days from the date of the agreement for local variations agreed during the term of the contract). In contrast, where there is a national currency but no national price, providers must submit details of local prices to Monitor by 30 June of each year.

45. Monitor is responsible for ensuring that commissioners comply with the rules on local variations set out in the national tariff.

46. During 2014/15 Monitor received 326 local variations. 80% were submitted after September 2014. The late submission of first applications made it difficult for Monitor to identify non-compliance and to work with commissioners to improve their compliance during 2014/15.

47. A benefit of publishing local variations is that it allows sharing of good practice with other providers and commissioners. Late submissions reduce the ability to share these experiences in time for the next commissioning and contracting cycle.

5.2.2. Proposal

48. We propose to amend the rules for local variations to establish a deadline of 30 June of each year for commissioners to submit to Monitor written statements on local variations which are included in the new commissioning contracts agreed for the year. Where local variations are made after the contract is agreed (in-year variations), the proposal is that the commissioner must submit a local

variation template within 30 days of the change being agreed between the commissioner and provider.

5.2.3. Rationale

49. We consider this proposal to be appropriate because:

    a. a standard date for submissions is easier for the sector to implement and is simpler for Monitor to enforce

    b. it will allow us to check compliance with local variations earlier in the year and inform commissioners by September of any changes needed to ensure compliance with the rules

    c. it gives commissioners and providers more time to review existing variations for the next commissioning round.

5.2.4. Options considered

50. We considered keeping the rules and guidance for submitting local variations to Monitor unchanged. Commissioners and providers are expected to have signed their contracts by the beginning of each financial year. Despite this, under the current arrangements, Monitor does not receive submissions from all commissioners and cannot begin to take enforcement action until towards the end of the financial year. This limits the benefit to the sector from collecting this information.

5.3. Local modifications

Summary

We propose to amend the method for granting an application for a local modification by introducing a deadline of 30 September in each year for providers to submit local modification applications to Monitor. We would only allow late submissions in exceptional circumstances, for example where there are risks to patients. The proposed deadline would help to mitigate the impact of local modifications on commissioner financial allocations.

5.3.1. Context

51. Local modifications are adjustments to national prices in cases where it would be uneconomic for a provider to provide a service at the nationally determined price as a result of unavoidable structural issues. These must be agreed by Monitor.

52. There are two types of local modification:

    a. Agreements reached between the commissioner and provider. The provider and commissioner would then make a joint submission to Monitor. We do not propose to change the current method for approving local modification agreements.

    b. Applications where the provider and commissioner cannot reach agreement so the provider makes an application to Monitor.

53. During 2014/15 providers could submit an application for a local modification at any time.

54. Submissions made after commissioning intentions and commissioner allocations have been set represent a risk to the commissioner and would affect the commissioning and contracting round.

55. An application for a local modification must be supported by sufficient evidence to enable Monitor to determine whether a local modification is sufficient.

56. For 2015/16, Monitor and NHS England have proposed, in guidance to providers and commissioners, that applications are submitted by 30 September 2015 (with exceptions where there is a risk to patients).

5.3.2. Proposal

57. We propose to change the method for granting local modification applications by introducing a deadline of 30 September each year. In most cases

applications received before this date would, if granted, take effect from the start of the next financial year.

58. We propose only to allow late submissions or earlier implementation in exceptional circumstances, for example, where there is a risk to patients that could not reasonably have been anticipated prior to the 30 September deadline.

5.3.3. Rationale

59. A deadline of 30 September in each financial year would enable commissioners to adjust plans and budgets for the following year, in line with the commissioning and contracting timetable. This would reduce the risk of a late application affecting the financial position of a commissioner.

5.3.4. Options considered

60. We considered the option of not setting a deadline. We rejected this option because it would have continued to pose a risk to commissioners of late applications. We consider that structural issues should reasonably have been identified, and negotiations on local modifications taken place, by the sixth month of the financial year. This means that it should be apparent by 30 September if a provider needs to apply to Monitor for a local modification.

6. Responding to this consultation

Summary

We welcome your responses to the policies proposed in this document. We have developed an online survey that can be found here.

61. Thank you for taking the time to read our proposals. If you want to provide feedback to any of the proposals contained within this document, we have set up an online survey that can be found here.[8]

62. We have set standard questions across each proposal to allow for comparability. These are summarised as:

    a. Do you feel that you have been provided with enough information to make an informed response?

    b. Do you believe that the advantages of this proposal outweigh the disadvantages?

    c. What advantages and disadvantages have we not considered in our proposal?

    d. What changes could we make to this policy to better achieve our objectives?

63. We will hold a number of workshops around these proposals over coming months. You can find out more about them at here.[9]

64. The deadline for responses to this consultation is 21 September 2015.

[8] Available at: www.research.net/r/CXPNFLS
[9] Available at: www.gov.uk/government/publications/engagement-on-201617-national-tariff-proposals

Annex 1: Impact assessment of proposed change to the marginal rate emergency rule

We are proposing that for emergency admissions above 2010/11 levels (adjusted where appropriate), providers should receive 70% of the national price. This is the policy which already applies for all providers receiving ETO prices. This policy is described in depth in Section 4.1 of this document.

This policy already applies to providers currently on the ETO, so its inclusion in the 2016/17 national tariff would not have an additional impact on those providers. However, we estimate it would increase the total revenue of providers on Default Tariff Rollover prices (and, therefore, increase commissioner expenditure) by approximately £16m.[10] This is around 0.2% of the total operating revenue of the providers affected.

[10] This calculation assumes that activity levels do not change, and that the changes to relative prices discussed in *2016/17 national tariff proposals: Currency design and relative prices* have been implemented.

Contact us

Monitor, Wellington House,
133-155 Waterloo Road,
London, SE1 8UG

Telephone: 020 3747 0000
Email: enquiries@monitor.gov.uk
Website: www.gov.uk/monitor

© Monitor (August 2015) Publication code: IRCP 12/15
NHS England Publications Gateway Reference 03541
NHS England Document Classification: Official