NHS Improvement

Preliminary assessment: 2017/18 and 2018/19 national tariff proposals

August 2016

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Summary

NHS Improvement and NHS England want the national tariff to act in the best interests of patients. Feedback on our proposals from stakeholders is crucial to achieve this. The 2017/19 tariff engagement document explains a number of policies that NHS Improvement and NHS England are proposing for the 2017/19 national tariff, the most significant of which are:

- a move to a two year tariff (covering 2017/18 and 2018/19),
- updates to national prices to reflect the HRG4+ phase 3 currency design and updated cost data,
- changes to specialist top-ups, and
- adjustments to specific prices with the intention of mitigating specific impacts

NHS Improvement and NHS England are seeking your feedback on these proposals. To inform your feedback, this preliminary assessment sets out the anticipated impact of the proposals on patients, providers and clinical commissioning groups (CCGs). We are also seeking feedback on this preliminary assessment.

In some areas we have upgraded our assessment methods, in response to findings from last year's enhanced impact assessment project.[1] In this project we sought to validate our impact assessment with a sample of providers. To address findings from the project we have altered the way we deal with changes to the scope of the national tariff, and with changes to the high cost drugs and devices list.

There are still some limitations to our assessment, and this should be borne in mind when reading this report. In some areas the data available is limited. The assessment of impacts in the second year of the proposed national tariff (2018/19) is purely qualitative at this stage. Also, any impact assessment involves predictions about future events and the effect that these could have, which by their nature are subject to uncertainty. The actual impacts may differ from our estimates.

In particular, it is important to note two assumptions we have made in our quantitative analysis. First, we have assumed that healthcare activity in 2017/18 remains constant at the level of the latest-available activity data.[2] Providers and commissioners may choose to respond to proposals by changing the mixture of healthcare activity. Second, we have assumed that all providers and commissioners are fully compliant with the national tariff.

We plan to develop our impact assessment between now and publication of the statutory consultation notice. This includes developing our approach to best practice tariffs, further responding to findings from last year's enhanced impact assessment

[1] See NHS Improvement 2016, *2016/17 National Tariff Payment System proposals: Impact assessment*, Annex 1, for more details on this project.
[2] 2014/15 Hospital Episode Statistics.

and quantitatively assessing impact for 2018/19 if we proceed with the proposal for a two year tariff. We are also re-running the enhanced impact assessment project this year, and where possible we will upgrade our method in response to any findings from this as well.

Overall Findings

Finding 1: For 69% of NHS providers, the two most significant policy proposals affecting 2017/18 spending (changes to national prices and specialist top-ups), taken together, would change operating revenue by less than +/-1%.[3][4] For 94% of NHS providers, the operating revenue change is less than +/-2%. Changes to operating revenue are most broadly distributed for specialist trusts; for 2 specialist trusts, operating revenue would fall by more than -3%, and for a further 3, operating revenue would increase by +2.9% or more. These impacts are largely driven by changes to national prices; national prices account for around 80 times as much provider revenue as specialist top-ups.

Finding 2: We estimate that taken together the proposed changes to national prices and specialist top-ups would decrease CCG spending by around £175 million, and increase NHS England spending by the same amount. This is mainly driven by changes to specialist top-ups (£97 million). They would not change the spending of any CCG by more than +/-1.3%.

National prices

Finding 3: For 45 of 67 types of care, the proposed prices would change spending by <+/-5%. Measured in absolute terms, the biggest spending increases would be in maternity (+8.3%, £221 million), emergency medicine (+6.5%, £132 million) and nervous system procedures and disorders (+6.3%, £72 million). The biggest reductions would be in non-admitted consultations (-£223 million, -4.4%), interventional cardiology for acquired conditions (-£115 million, -12.1%),and Eyes and Periorbita Procedures and Disorders (-£71million, -9.3%).

Finding 4: For 73% of NHS providers who deliver nationally-priced services, the proposed national prices would change operating revenue by less than +/-1%. For 94% of NHS providers, the operating revenue change is less than +/-2%. The changes to operating revenue are most narrowly distributed for teaching and non-acute hospitals, and most broadly distributed for specialist hospitals. NHS Improvement and NHS England are considering whether and how to mitigate revenue volatility, particularly for the most-affected providers.

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[3] This analysis excludes NHS providers with no nationally-priced revenue.

[4] NHS Improvement and NHS England have considered a number of scenarios for specialist top-ups. For simplicity, we have focused this analysis on just one top-up scenario (scenario 5), which is described in Section 6.

Finding 5: The proposed national prices would reduce independent provider nationally-priced revenue by 2.5%, from £1.11 billion to £1.09 billion. This is largely driven by price reductions for orthopaedic non-trauma procedures (sub-chapter HN).

Finding 6: For all CCGs, proposed national prices would change spending by less than +/-1.3% of their funding allocation The national prices would increase NHS England spending by £35 million.

Specialist top-ups

Finding 7: NHS Improvement and NHS England's preferred scenario for specialist top-ups would increase specialist top-ups spending from £323 million to £417 million. This increase is caused by the introduction of top-ups in several new areas (including cancer, respiratory and cardiac) totalling £100 million, as well as a £21 million increase in neurosciences, partly counterbalanced by a fall in spending on other existing top-ups areas.

1. Introduction

NHS Improvement and NHS England want the national tariff to act in the best interests of patients. Feedback on tariff proposals from stakeholders is crucial for achieving this. The 2017/19 tariff engagement document explains a number of policies that NHS Improvement and NHS England are proposing for the 2017/19 national tariff, and asks for your feedback. To inform your feedback, this report provides NHS Improvement's preliminary assessment of the impact on patients, providers and commissioners of these proposals**.**

1.1. Our impact assessment approach

Our impact assessment looks at how NHS Improvement and NHS England's proposals might affect providers, commissioners and patients in 2017/18. In conducting the assessment, we have followed the principles in our 2015/16 Impact Assessment Framework.[5] That is, we have aimed to make our assessment proportionate, transparent, evidence-based, policy-specific, compared to an appropriate baseline, and robust to key assumptions.

This means that the methods used in our assessment vary from proposal to proposal. In particular, what is proportionate depends on the size of the change proposed, likely stakeholder interest and the amount of data available. Therefore, some areas of this assessment use quantitative analysis while others are more qualitative. We describe our assessment method within each section.

In some areas we have upgraded our assessment methods in light of findings from last year's enhanced impact assessment project.[6] In this project, we shared with a sample of providers our assessment of the impact of draft prices on their organisation, and asked them to compare this with their own assessment. Where there were material differences, we investigated improvements we could make to our impact assessment approach. We found, among other things, that we could improve the way we dealt with changes to the scope of the national tariff, and with changes to the high cost drugs and devices lists. The changes we have made are discussed in the relevant sections of this report.

Any impact assessment involves predictions about future events and the effect that these could have, and these are subject to uncertainty. Therefore, the actual impact may differ from the estimates we present. The assessment of impacts in the second year of the proposed national tariff (2018/19) is purely qualitative at this stage.

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[5] NHS Improvement (2014), 2015/16 National Tariff Payment System: Impact Assessment Framework.

[6] See Annex 1 of Monitor's 2016/17 National Tariff Payment System Proposals Impact Assessment www.gov.uk/government/uploads/system/uploads/attachment_data/file/499481/Impact_assessment_final.pdfwww.gov.uk/government/uploads/system/uploads/attachment_data/file/499481/Impact_assessment_final.pdf

Also, the quantitative analysis in this report makes two important assumptions:

- That the mixture of care offered by every provider, and commissioned by every commissioner, stays the same. We recognise that providers and commissioners are likely to alter activity levels or how services are commissioned in response to the proposed prices. However, we consider that analysis that assumes constant activity is the best way to help readers understand the proposed price changes. Activity changes would also be challenging to predict accurately.
- That all providers and commissioners are fully compliant with the national tariff. This may not always be the case. We are aware, for example, that in the past some providers have agreed block contracts for areas of care that are covered by national prices. However, we do not hold NHS-wide data on current levels of compliance with the national tariff.

We plan to develop our impact assessment approach further before publication of the statutory consultation notice on the national tariff later this year. Areas we are considering include:

- assessment of the impact of introducing a two-year tariff
- our approach to best practice tariffs (BPTs)
- working with NHS England to gather more data on high cost drugs and devices, to strengthen our assessment in this area
- estimation of administrative burden, and
- equalities analysis to assess the impact of the final proposals on patients across different demographics.

We have nearly completed work to improve our data on the market forces factor of independent sector providers (another finding from last year's enhanced impact assessment). This will be included in our impact assessment for the statutory consultation notice.

We are running the enhanced impact assessment again this year. We have worked with NHS Providers, NHS Partners and NHS Clinical Commissioners to find volunteer organisations, from whom we have picked a sample designed to be as representative of the sector as possible. Where we can, we will address findings from this process before publishing the statutory consultation notice. We will look at any findings we cannot address by then in future impact assessments.

In your response to the tariff engagement document, we would like to hear about the areas where you would like more impact assessment alongside the statutory consultation. We also encourage you to tell us any other information about the impact of these policies that you think we should take account of.

1.2. This report

This report is structured as follows:

- **Sections 2 and 3** assess the impact of proposals for **prices.** NHS Improvement and NHS England are proposing to introduce new national prices, based on phase 3 of the HRG4+ currency design and 2014/15 reference cost data, with manual adjustments and proposed changes to the method for calculating national prices to uplift a targeted set of prices[7] where appropriate. We also propose to make other policy changes whose main effect will be to change prices. This includes, increasing the scope of national prices, making alterations to maternity pathway prices, making price changes following changes to the high cost drugs and devices list, and making some adjustments to non-mandatory prices. These changes are described in sections 4, 6 and 9 of the tariff engagement document. Because all of these proposals change national prices, we considered it made sense to assess their impact jointly.

  For most national prices, we can do a full quantitative assessment by applying draft (2017/18) and current (2016/17) prices to the most recent available activity data and looking at the difference between the two, as measured by changes in provider revenue, commissioner spending, and patients receiving different types of care. **Section 2** provides that assessment, which covers prices accounting for around 97% of nationally-priced spending.[8] The remaining prices could not be included in this section due to data limitations. We assess these prices separately in **section 3.**
- **Section 4** outlines the impact of proposals for **BPTs.**[9]
- **Section 5** outlines at a high level the qualitative impact of the proposal to set a **two-year tariff**.
- **Section 6** assesses the impact of proposals for **top-up payments for specialised services.** [10]
- **Section 7** assesses the impact of proposals for changes to the **local pricing rules.**[11]
- **Section 8** combines the analysis from Sections 2 to 7 to assess, to the extent possible, the **combined impact** of the tariff engagement proposals as a

[7] The affected prices are those in specific subchapters in the chapters H ('HC', 'HD', 'HN', and 'HT'), P ('PB'), and S (SC' and 'SB'), and Renal Dialysis ('LD'). See National tariff proposals for 2017/18 and 2018/19, section 6.
[8] The most recent available activity data is 2014/15 Hospital Episode Statistics.
[9] *National tariff proposals for 2017/18 and 2018/19*, sections 5 and 6.4.
[10] *National tariff proposals for 2017/18 and 2018/19*, section 3.
[11] *National tariff proposals for 2017/18 and 2018/19*, section 8.

whole on providers, commissioners and patients and sets out our proposals for assessing the equalities impact of the proposed tariff.

- **Section 9** discusses the approach we plan to take to assessing the **competition** impact of the tariff engagement proposals as a whole.

We do not describe policy proposals in depth in this report, to avoid repeating the tariff engagement document. All of NHS Improvement and NHS England's proposals are described in detail in the tariff engagement document, and we suggest reading this report alongside it.

This report covers all proposals in the tariff engagement document, except the proposed innovation and technology tariff.[12] Given that the technologies for inclusion have not yet been selected, we did not consider this proposal was at an advanced enough stage to be meaningfully assessed.

[12] *National tariff proposals for 2017/18 and 2018/19*, section 5.12

2. National prices quantitative assessment

NHS Improvement and NHS England propose to introduce new national prices. These would be based on phase 3 of the HRG4+ currency design and 2014/15 reference cost data, with manual adjustments where appropriate. They would also reflect a number of other policy changes, such as an update to the assumptions underlying the maternity pathway (which will affect national prices for maternity services). These proposals are discussed in sections 4 and 6 of the tariff engagement document. In general, they expect the proposals to help providers plan more effectively with commissioners, to deliver better care for patients.

In this section we quantitatively assess the impact of these proposals. We have excluded a small number of national prices (covering around 3% of nationally-priced spending) from the assessment in this section due to data limitations. We assess the national prices that have been excluded from this section in section 3. This analysis does not consider the impact of any possible price changes arising from adjustments for inflation, efficiency, and the Clinical Negligence Scheme for Trusts (CNST), as the policy proposals for them are still being developed. The impact assessment report for the statutory consultation notice will consider them.

2.1. Methodology

The quantitative analysis in this section simulates payments under the proposed national prices and currencies and compares them to payments under current prices (the 2016/17 national tariff).[13] It does this by applying both sets of prices to the most recent available activity data[14], and assumes that the activity remains constant. We use these simulated payments to assess the impact of the proposed price changes on payments for different types of care, provider revenue and commissioner spending.

2.2. Impact by type of care

In this subsection, we illustrate the impact of proposed prices on spending on different types of care.

The care categories we use when describing price changes are mostly HRG subchapters. In the HRG system HRGs are split into chapters, with each chapter generally relating to care for a particular body area or body system. For example, in the HRG4+ design 'Chapter A' relates to the 'Nervous System' while 'Chapter K' is for the 'Endocrine and Metabolic System'. Chapters are further divided into subchapters, which cover different categories of care for the body area or body

[13] See NHS Improvement 2016, *2016/17 National Tariff Payment System: A Consultation Notice*
[14] The most recent available activity data is 2014/15 Hospital Episode Statistics.

system. For example, Chapter A is further divided into subchapters AA ('Nervous System Procedures and Disorders'), and AB ('Pain Management').

There is one subchapter (WF, Non-Admitted Consultations), which does not relate to care for a particular body area or body system. This sub-chapter covers payment for appointments when patients are seen by a healthcare professional but do not receive a procedure which has a national price. It covers all types of care.

We also use one care category, 'Maternity', which is slightly larger than a subchapter. NHS Improvement and NHS England are making changes to the maternity pathway to update casemix assumptions.[15] HRG4+ currency design does include a subchapter called 'Maternity', which covers births. However, in addition to the birth, providers also receive payments for care during the antenatal and postnatal phases of pregnancy. In all of our analysis, 'Maternity' refers to payments for all three phases of pregnancy (antenatal, birth and postnatal).

2.2.1. Findings by type of care

For 45 of 67 types of care, the proposed prices would change spending by between +/-5%. Measured in absolute terms, the types of care where proposed prices would cause the biggest increases in spending are:

- **Maternity.** Spending would increase by £221 million, around 8.3.% of total maternity spending
- **Emergency medicine (subchapter VB).** Increase of £132 million (6.5%)
- **Nervous system procedures and disorders (subchapter AA).** Increase of £72 million (6.3%)

Conversely, the subchapters where proposed prices would cause the biggest reductions in spending are:

- **Outpatient attendances (subchapter WF).** Decrease of £223 million (-4.4%)
- **Interventional cardiology for acquired conditions (subchapter EY).** Decrease of £115 million (-12.1%)
- **Eyes and periorbital procedures and disorders (subchapter BZ).** Decrease of £71 million (-9.3%)

[15] *National tariff proposals for 2017/18 and 2018/19*, section 3

Figure 1: Changes in nationally-priced spending on different types of care

Source: NHS Improvement analysis

Notes

1. 'NZ Obstetric Medicine' refers to Maternity
2. For formatting reasons we have used some abbreviations when labelling types of care. These are:
    a. P & D – Procedures and Disorders
    b. H & P – Hepatobiliary and Pancreatic
    c. U & M – Urological and Male
    d. D, E & M – Diabetology, Endocrinology and Metabolic
    e. P, TE, SE, S – Poisoning, Toxic Effects, Special Examinations, Screening
    f. O & I – Open and Interventional

The movements noted above are driven by a number of different factors, which we are doing further work to explain. We would expect basing prices on more up-to-date cost data to change the prices. Also, because the HRG4+ phase 3 currency design is designed to better reflect patient complexity, we would expect it on average to reduce prices for simpler care and increase prices for more complex care. Interacting with this effect, we have uplifted 8 targeted subchapters' prices[16], as outlined above. This has limited the estimated scale of the impact under the proposed tariff to between -0.7% and -3.3%. For example, the subchapter Orthopaedic non-trauma procedures ('HN') estimated loss is -£60 million (-2.5%). Some price movement has also been caused by manual adjustments to prices following feedback from Expert Working Groups. In our statutory impact assessment that will accompany the statutory consultation notice we will provide further analysis on these areas.

As discussed in the tariff engagement document, NHS Improvement and NHS England are currently looking at the causes of the large movements they have observed for some types of care, such as orthopaedics, and considering the extent to which they wish to mitigate them.[17]

2.3. Impact on organisations

In this subsection we assess the impact of the proposed national prices on the revenue of NHS and independent providers, and on the spending of clinical commissioning groups (CCGs) and NHS England.[18] The underlying analysis (a simulation of nationally-priced payments under both current and proposed prices, using the latest activity data) is the same as in the previous subsection.

We express impacts in the way we consider gives the best understanding of how material the impact is for the organisation. For NHS providers, we express impact as a percentage of operating revenue. We do not hold equivalent data for independent providers, so instead we express their revenue changes as a percentage of nationally-priced revenue. For CCGs we use total funding allocation, and for NHS England total direct commissioning spend.

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[16] Uplifted draft prices have occurred in subchapters ('HC', 'HD', 'HN', 'HT', 'PB' 'SC', 'SB', and 'LD'). For further details see the *National tariff proposals for 2017/18 and 2018/19*, section 6.

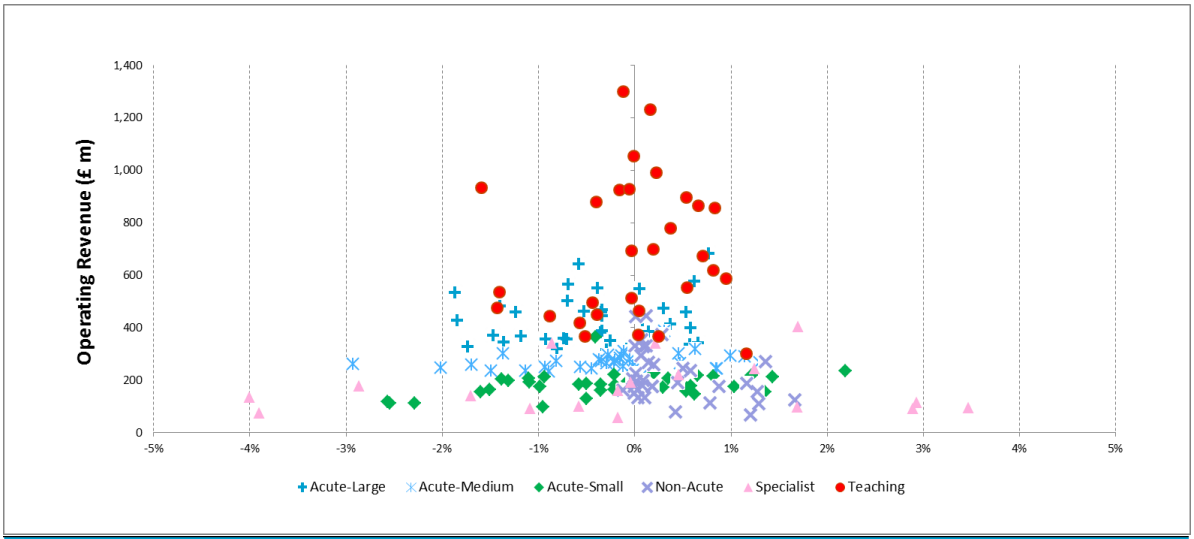
[17] *National tariff proposals for 2017/18 and 2018/19*, section 6.5.

[18] We have included all NHS organisations that submitted tariff-related activity data through HES 2014/15 in our assessment.

2.3.1. NHS Providers

For 144 NHS providers (73% of the providers included in our analysis), the proposed prices would change operating revenue by less than +/-1%. For 184 NHS providers (94%), proposed prices would change operating revenue by less than +/-2%. **Figure 2** shows the revenue impact for all NHS providers. Our analysis excludes NHS providers with no nationally-priced revenue.

Figure 2: Change in NHS Provider nationally-priced revenue



Change in Operating Revenue	Acute - Large	Acute - Medium	Acute - Small	Specialist	Teaching	Non-Acute	All
5% <= x	0	0	0	0	0	0	0
4% <= x < 5%	0	0	0	0	0	0	0
3% <= x < 4%	0	0	0	1	0	0	1
2% <= x < 3%	0	0	1	2	0	0	3
1% <= x < 2%	0	2	4	3	1	7	17
0% <= x < 1%	11	9	11	2	14	27	74
-1% <= x < 0%	17	18	14	5	12	4	70
-2% <= x < -1%	8	4	6	2	3	0	23
-3% <= x < -2%	0	2	3	1	0	0	6
-4% <= x < -3%	0	0	0	1	0	0	1
-5% <= x < -4%	0	0	0	1	0	0	1
x < -5%	0	0	0	0	0	0	0
Total	36	35	39	18	30	38	196

Source: NHS Improvement analysis

Looking at the impact on different provider types, for around 72% of large, medium and small acute providers the impact would be within +/- 1% of operating revenue, with the impact on almost all of the remainder (95%) within +/-2%. The impact on non-acute providers and teaching hospitals is more narrowly distributed. For both, the impact on over 84% of providers is within +/-1%. The impact on specialist trusts is more varied:

- Three specialist trusts would have the highest increases in operating revenue (each increasing by over 2.9%, with the highest at 3.5%).
- Two specialist trusts (the orthopaedic specialists) also have the largest falls in operating revenue (falling by around -4% in both cases).

The wider distribution in impact for specialist trusts is at least partly caused by their specialisation. For non-specialist providers, revenue decreases for some types of care can be partially balanced by revenue increases for other types of care. Broadly speaking, specialist providers only deliver one type of care, so this balancing effect does not happen for them. For example, the majority of nationally-priced revenue for the three orthopaedics providers comes from chapter H (Orthopaedics), for which total nationally-priced spending would fall from around £4.4billion to £4.3 billion (a 1.6% reduction). As noted above, NHS Improvement and NHS England are doing further work on understanding the causes of these effects and ways of mitigating them.

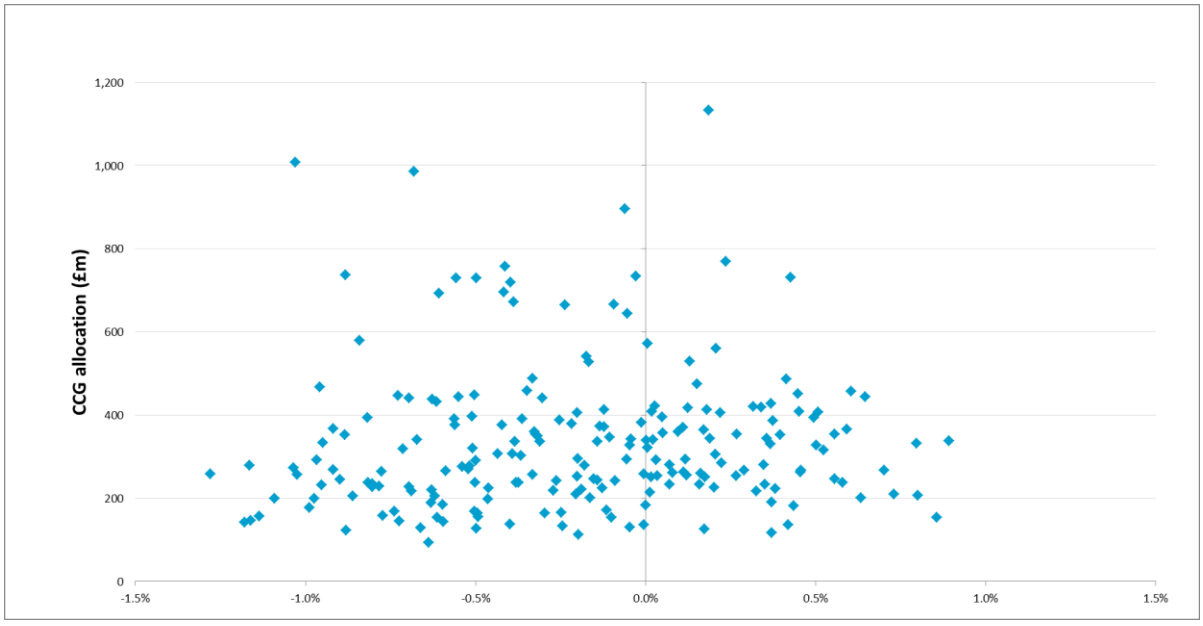
2.3.2. Independent sector providers

We estimate that proposed prices would cause total independent sector provider revenue from nationally priced services to fall by 2.5% (£28 million) from £1.11 billion to £1.09 billion. This fall is largely driven by chapter H (Orthopaedics), where independent provider revenue decreases by £20 million (-1.8%). This is a significant decline in revenue for independent sector providers. As noted above, NHS Improvement and NHS England are looking at ways to mitigate the impact on providers that would be particularly adversely affected by the proposed tariff.

2.4. Impact on commissioners

For all CCGs, proposed prices would change spending by less than +/-1.3% of their funding allocation. **Figure 3** illustrates the impact for individual CCGs.

Figure 3: Impact on Commissioners



Source: NHS Improvement analysis

Overall, when considering national prices alone, total NHS England spending would increase by around £35 million, driven by an increase in inpatient spending for central commissioners under the proposed tariff (a £64 million increase), while CCG spending would fall by around £132million (a net loss of around £97 million).

This estimated loss is largely due to a proposed increase in specialist top up spending. NHS Improvement and NHS England policy is that changes to top-ups should not affect total NHS spending. Where spending on top-up payments increases, this is funded by reducing all prices for admitted patient care slightly, so that total NHS spending stays the same. The proposed national prices have been reduced in line with the assumption that one of top-up scenarios 3-5 (all of which increase top-ups spending) is implemented. [19] Specialist top-ups are discussed in detail in Section 6.

[19] The prices proposed in the tariff engagement document have been reduced in line with scenario 3, 4 or 5 being implemented.

3. Prices outside our quantitative assessment

Section 2 provides our quantitative assessment of proposed national prices. As we noted in Section 2, there are a small number of prices which, due to data limitations, we could not include in our quantitative assessment. Non-mandatory prices (which form part of the proposals but are not formally national prices) are also excluded from the assessment in Section 2. The full set of prices excluded from Section 2 (which together account for around 3% of nationally-priced spending) is:

- unbundled diagnostic imaging
- 'other national prices'
- prices substantially affected by changes to the high cost drugs and devices lists
- prices that are newly in the scope of national prices.
- non-mandatory prices

In this section we assess the impact of the proposed changes to these prices.

3.1. Unbundled diagnostic imaging

Unbundled diagnostic imaging covers payments for various imaging procedures such as MRI scans and echocardiograms. Total spending on these procedures is around £816 million.[20] NHS Improvement and NHS England are proposing to set new prices for these services based on the HRG4+ phase 3 currency design and updated cost data.

3.1.1. Methodology

The proposed move to HRG4+ phase 3 would substantially change the currency design for these procedures. Under HRG4, there are 50 HRGs; under HRG4+ there would be 115.[21] While our preliminary analysis indicates that around a third of unbundled diagnostic imaging HRGs are identical in both currency designs, the remainder are not.

We do hold some diagnostic imaging activity data, but the change in currency design makes it difficult to use this data for quantitative impact assessment. Ideally, we would assess impact by applying both current and proposed prices to the latest activity data. However, the latest activity data we have comes from 2014/15 provider reference costs submissions, and thus is structured according to the HRG4+ currency design.[22] As proposed prices are also in the HRG4+ phase 3 currency

[20] Under proposed 2017/18 prices.
[21] A new subchapter (RN) has been created from the old nuclear medicine subchapters and has been made significantly more granular (hence the large increase in HRGs).
[22] Unbundled diagnostic imaging is not well-recorded in Hospital Episode Statistics, which is the main source of activity data for our impact assessment.

design, we can apply prices to activity to estimate each provider's revenue under proposed prices. However it is not straightforward to apply current prices to the same activity data, because current prices are based on a different currency design (HRG4).

We are working to develop a methodology for quantitatively assessing the impact of the proposed changes to diagnostic imaging. We hope to include this in the impact assessment report accompanying the statutory consultation notice.

3.1.2. Assessment

Introducing a new subchapter with significantly more granular HRGs should lead to prices that better reflect efficient costs of provision. We are in the process of investigating how old and new currencies map to each other to understand the impact this may have.

3.2. Other national prices

'Other national prices' cover four groups of services:

- direct access services[23]
- rehabilitation and post discharge
- cystic fibrosis
- looked after children's health assessments.

NHS Improvement and NHS England propose to keep current prices for these services with the exception of the direct access services, where prices will be set based on updated cost data.[24]

3.2.1. Methodology

We assessed these proposals qualitatively.

3.2.2. Assessment

Prices that are kept the same are likely to become less cost-reflective over time. However, NHS Improvement and NHS England do not currently have sufficiently robust cost data for these services to develop up-to-date robust prices.

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[23] According to the NHS Dictionary, direct access services are services to which patients are directly referred from primary or community care for both diagnosis and treatment. See www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/d/direct_access_service_de.asp?shownav=1

[24] Prices that are kept the same will still be subject to adjustments affecting the overall level of prices, such as the efficiency factor and inflation uplift, when these are decided.

For direct access services, prices based on more up-to-date reference costs should better reflect the efficient cost of providing the services. This will send appropriate price signals to providers and commissioners, helping them make best use of resources.

3.3. Prices significantly affected by changes to the high cost drugs and devices lists

Sections 4.5 and 4.6 of the engagement document outline a number of devices that NHS Improvement and NHS England propose to remove from the high cost drugs and devices lists. This includes, for example, aneurysm coils and intracranial stents.

Items on the high cost drugs and devices lists are outside the scope of national prices. Providers and commissioners agree local prices for these items in accordance with the local pricing rules. Moving an item off the list and into the scope of national prices increases the national price for procedures using the item, because the price has to go from paying for just the procedure to paying for the procedure and the item.

3.3.1. Methodology

Last year, during our enhanced impact assessment project, we found that our impact assessment was biased by the way it dealt with changes to the high cost drugs and devices list. For prices affected by changes to the lists, our assessment was not fully comparing like with like, because it compared the proposed national prices (covering both the procedure and the drug/device) with current national prices (covering just the procedure). This made the revenue impact of the proposed price changes appear more positive than it was.

We have since improved the way we deal with changes to the high cost drugs and devices lists. To assess accurately the impact of the price changes caused by changes to the list, we would need to compare the proposed national price (covering both procedure and item) with the sum of both the current national price (covering the procedure) and current locally-agreed prices for the item. However, we cannot do this because we do not hold data on locally-agreed prices. Therefore, to avoid a biased assessment, we have instead removed the 41 HRGs significantly affected by changes to the drugs and devices lists from our main assessment of national prices in section 2.[25] We are also working with NHS England to gather data on local prices for items proposed to be removed from the high cost drugs and devices lists, and hope to include this in our impact assessment for the statutory consultation notice.

In this section we provide an assessment based on the data we have. We use 2014/15 reference costs to estimate how the proposed changes would affect

[25] We define ‘significantly affected’ as a change of over 10%.

nationally-priced spending, and qualitatively consider what this would mean for providers, commissioners and patients. Note that this assessment does not consider the effect of any manual adjustments to prices.

3.3.2. Assessment

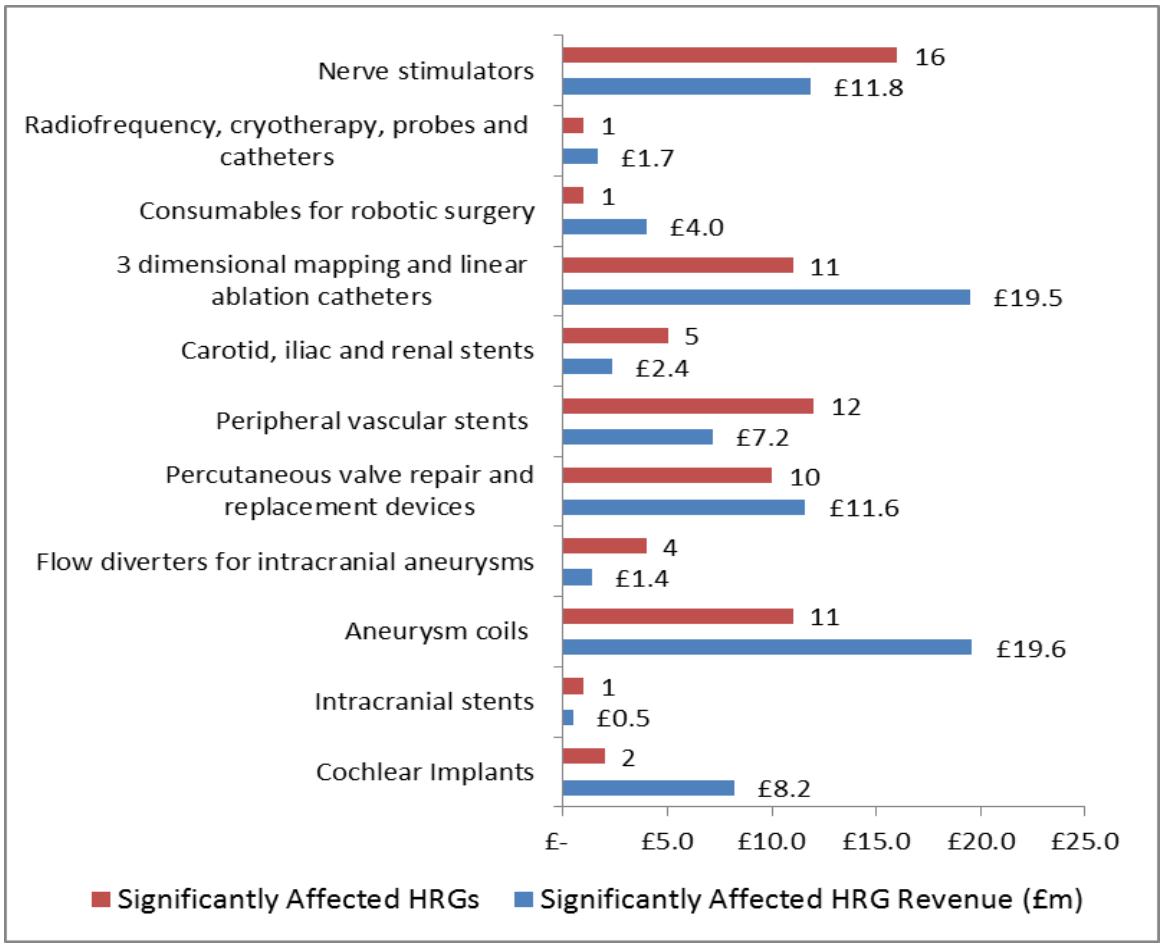
We estimate that, without taking into account any subsequent manual adjustments, moving the proposed devices off the high cost list and into national prices would add around £158 million to nationally-priced spending. For most HRGs there would be little or no effect on prices. However, for 41 HRGs the price would change by more than 10%.[26]

NHS Improvement and NHS England are reviewing the methodology they use to allocate drug and device costs to HRGs. Our estimates would be affected if they change this methodology before the statutory consultation.

Figure 4 shows the total nationally-priced spending effect, and the number of HRGs affected by more than 10%, for each device.

[26] Specifically, the price for at least one point of delivery (day case, elective or non-elective) within these HRGs would change by more than 10%.

Figure 4: Significantly affected HRGs and revenue (£m) by device



Source: NHS Improvement analysis

The impact of these changes on providers, commissioners and patients will depend on local prices for these devices. These will determine how the changes affect each provider's revenue and each commissioner's spending. In turn, the effect on provider revenue and commissioner spending may affect patients by changing the mix of services offered, but in ways that are difficult to predict. For example, if the total price for a procedure and device goes up, commissioners may wish to commission fewer but providers may wish to offer more.

3.4. Increasing the scope of national prices

Section 4.2 of the tariff engagement document outlines several services that NHS Improvement and NHS England propose to move into the scope of national prices. They cover cochlear implants, complex CT scans, complex therapeutic endoscopic gastrointestinal tract procedures, and photodynamic therapy. The tariff engagement document notes that implementing these national prices would not create an administrative burden on the service as HSCIC would update the grouper so payments will be made automatically. In addition, implementing new national prices for these services should reduce the burden related to agreeing these prices locally.

3.4.1. Methodology

Last year, during the enhanced impact assessment, we found that our impact assessment was biased in how it dealt with increases to the scope of national prices. Our estimate of provider revenue with proposed prices included revenue relating to new-in-scope prices, while our estimate of provider revenue relating to current prices did not include the current locally-priced revenue for this activity. This made the revenue impact of the proposed price changes appear more positive than it was.

We have improved our approach to changes to the scope of national prices. Ideally, we would consider current locally-priced revenue for these services in our impact assessment. However, we do not hold the data to do so (although we are considering collecting it in the future). To avoid a biased assessment, we have instead removed all revenue relating to new-in-scope prices from our estimates in Section 2 of provider revenue under both current and draft prices. We have not been able to quantify some of the effects of the changes to the scope of national prices. However, we intend to do so in time for the impact assessment published alongside the statutory consultation notice later in the year.

Here we provide the assessment that is currently possible: an estimate of how these changes will affect total nationally-priced spending, and qualitative consideration of how that might affect providers, commissioners and patients.

3.4.2. Assessment

We estimate that moving the proposed HRGs into the scope of national prices would add a total of £170 million to nationally-priced spending.

We cannot draw firm conclusions on how these changes would affect providers, commissioners and patients. This will depend on two main factors.

- **Current local prices for these services.** These will determine the overall impact of the proposed changes on provider revenue and commissioner spending. Also, if proposed prices are closer to efficient costs than current local prices, moving to proposed prices would increase allocative efficiency.
- **Level of negotiation involved in current local prices.** In principle, one major benefit of setting a national price for a service is to remove the need for local negotiations. This saves effort for both providers and commissioners. It also, to the extent that national prices are available before locally-negotiated prices, makes it easier for providers and commissioners to plan. Therefore, the more negotiation is involved in setting current local prices the greater the benefits of introducing national prices will be. The extra administrative burden of using these prices would be negligible.

3.5. Non-mandatory prices

Non-mandatory prices are published with the national tariff for guidance only and are not formally part of the national tariff under the 2012 Act. For 2017/19, NHS Improvement and NHS England propose to:[27]

- Introduce new non-mandatory prices for a number of currencies.
- Update some existing non-mandatory prices using the latest cost data, while keeping current prices for the remainder.
- Introduce new non-mandatory currencies, e.g. for wheelchair services
- Remove the non-mandatory cataracts BPT

3.5.1. Methodology

We assessed these proposals qualitatively.

3.5.2. Assessment

Introducing new non-mandatory prices, and updating existing non-mandatory prices, would have similar benefits. Where non-mandatory prices are based on up-to-date data they can provide a more reliable benchmark of efficient costs than locally negotiated prices, which, in turn, helps providers and commissioners to make better-informed decisions.

Non-mandatory prices that are kept the same are likely to become less cost-reflective over time. However, no robust cost data currently exists for many of these prices. NHS Improvement and NHS England are considering work to refine the cost data for these services in the future.

Introducing new non-mandatory currencies for the sector to test would hopefully lead to more effective mandatory currencies for these services in future, which would benefit providers and commissioners. It may cause a small administration burden.

Removing the non-mandatory BPT should slightly reduce the administration burden on both providers and commissioners.

[27] *National tariff proposals for 2017/18 and 2018/19*, Section 9

4. Best practice tariffs

Best practice tariffs (BPTs) are designed to incentivise better patient care by setting a different price for care that meets specific criteria for best practice. Sections 5 and 6.4 of the engagement document contain a full description of the BPT changes that NHS Improvement and NHS England propose. They include setting new BPT prices based on the HRG4+ phase 3 currency design and updated cost data, as well as introducing some new BPTs and retiring others. They also propose simplifying the methodology for calculating BPTs.

4.1. Methodology

We have not been able to assess the impact of the BPT proposals due to timing. Proposed BPT prices were only finalised shortly before publication of this report. Also, to fully identify fully which activity is eligible for a BPT payment under proposed prices we would have needed to use the engagement grouper published alongside this report; again, this was not available until shortly before publication.

We plan to include a comprehensive assessment of the impact of changes to all BPTs in the impact assessment we publish with the statutory consultation.

5. Two year tariff

To date, NHS Improvement and NHS England have set each national tariff for a one year period. This allows them to review policies each year to respond to changes and new developments. However, in a period of significant uncertainty and financial challenge for the NHS, they now believe that setting the tariff for a two year period would offer greater stability and certainty to the sector. NHS Improvement and NHS England are therefore proposing to publish a national tariff covering both 2017/18 and 2018/19. [28]

5.1. Methodology

We have not assessed the impact of this proposal quantitatively. We have, however, undertaken an initial qualitative assessment. Since this proposal does not directly affect prices for 2017/18, but only those for 2018/19, we have concentrated our qualitative impact assessment on the latter year. We will provide a more in-depth assessment alongside the statutory consultation, which will among other things quantify the impact of the second year of proposed prices.

5.2. Assessment

We consider that the high-level advantages of this approach are that:

- Committing to prices for two years, rather than one year, in advance, will enable providers to plan their businesses further ahead. This should enable them to better assess the financial implications of making capital investments, such as expenditure on expensive machinery.
- By removing the need for a national tariff consultation next year, the proposal should cause a significant reduction in administration burden on providers, commissioners, NHS Improvement and NHS England.

The disadvantages of this approach are that:

- Since NHS Improvement and NHS England will set the tariff for two years, rather than one, the actual figures for inputs such as inflation or the cost base could differ significantly from the assumptions made when the tariff was set. This could result in prices that do not reflect costs, which could jeopardise the financial position of some providers, and result in inappropriate price signals.
- If the actual costs and other inputs used in setting the second year of the tariff do move significantly away from the assumptions in the statutory consultation notice, there could be a greater change in some prices than would otherwise be the case. This would reduce stability in the sector.

[28] *National tariff proposals for 2017/18 and 2018/19*, section 3.

Overall, given the feedback we have received from providers, we consider that the advantages of increased stability and the improved business planning which results, together with the reduction in the administrative burden, are likely to outweigh the disadvantages which could flow from the increased divergence of costs (and therefore prices) from the assumptions made when they were set.

6. Top-up payments for specialised services

Top-up payments for some specialised services were introduced in 2005/06 to reflect the extra costs for providers who systematically serve more complex patients requiring specialised services. Top-up payments are extra payments that providers receive in addition to the national price for a service, and are set at a percentage of the national price.

This year NHS Improvement and NHS England are considering making changes to specialised services top-ups, in light of changes to the way specialised services are defined. The changes would affect both 2017/18 and 2018/19. Previously, the services counting as 'specialised' were defined by the Specialist Services National Definition Set (SSNDS).NHS England has replaced this with a new Prescribed Specialist Services (PSS) list. Following an econometric analysis, the University of York has made recommendations on which services on the PSS list should receive top-ups, and what the top-up rates should be.[29,30]

NHS Improvement and NHS England have considered five scenarios for specialised services top-ups:

- **Scenario 1: SSNDS top-ups.** Keeping the current SSNDS based top-ups, which pay for services in four areas (neurosciences, orthopaedics, paediatrics and spinal).[31]
- **Scenario 2: University of York PSS top-ups proposal.**[32,33] This comprises top-up payments at different rates for 35 services.
- **Scenario 3: University of York proposal updated for change in currency design.** The University of York's analysis was based on phase 2 of the HRG4+ currency design. However, NHS Improvement and NHS England are proposing to introduce HRG4+ phase 3. The difference in currency design could affect the results of the analysis. NHS Improvement and NHS England took the PSS rates from York's work based on HRG4+ phase 2 and updated

[29] *How much should be paid for Prescribed Specialised Services?* (available at: www.york.ac.uk/che/news/2015/che-research-paper-118/

[30] We provided a detailed description of the PSS rules and our application of the York methodology in *Proposed reforms to top-up payments for specialised services* (available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/477498/Top-up_payments_for_specialised_services_finalwithcover.pdf

[31] See HSCIC website for a full code list an description of the SSNDS: www.hscic.gov.uk/article/4196/Archive-Prescribed-Specialised-Serviceswww.hscic.gov.uk/article/4196/Archive-Prescribed-Specialised-Services

[32] *How much should be paid for Prescribed Specialised Services?* (available at: www.york.ac.uk/che/news/2015/che-research-paper-118/

[33] For a full description of our methodology, please see: *Proposed reforms to top-up payments for specialised services* (available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/477498/Top-up_payments_for_specialised_services_finalwithcover.pdf)

them for areas that have undergone significant currency redesign between phases 2 and 3.[34] This caused adjustments to 7 of the 35 rates.

- **Scenario 4: University of York proposal updated for change in currency design, with 4 year transition for orthopaedics and paediatrics.** Option 3 would cause reductions in top-up payments for paediatrics and orthopaedics. This would have negative effects on the revenue of some providers. NHS Improvement and NHS England are considering transitional arrangements for these areas while they develop supporting polices to address patient complexity. Option 4 involves a four year transition for orthopaedics and paediatrics, such that only 25% of the proposed shift of income in these areas is implemented in 2017/18.

- **Scenario 5: University of York proposal updated for change in currency design, with 4 year transition for orthopaedics, paediatrics and spinal.** Scenario 5 includes additional transition for spinal services, which receive SSNDS top-up payments but would not otherwise receive any PSS top-up payments. Other than this, scenario 5 is similar to scenario 4.

In this section we assess the impact of these scenarios. NHS Improvement and NHS England do not currently consider that scenarios 1 to 3 are likely to be appropriate, and their current preference is scenario 5.

6.1. Methodology

We keep national prices fixed at the level proposed in the 2017/19 tariff engagement document and vary only top-ups.[35] This allows us to describe the impact of only the different top-up scenarios on commissioners, providers and different types of care. [36]

We identify PSS activity using the latest version of the official tool for this, as well as some planned updates to it which NHS England has notified us of, but which have not yet been included in the tool.[37] We will continue to work with NHS England's specialised commissioning team to ensure that our modelling incorporates any further updates to the PSS tool.

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[34] They used the latest year's PLICS data grouped under the two currency designs to measure the movement of costs between the two currencies and then applied the ratio of this movement to the HES data costs in order to arrive at a figure for adjusting the rates.

[35] For technical reasons, slightly more national prices underlie the analysis in this section than underlie the analysis in Section 2. For Section 2 we excluded 41 HRGs substantially affected by changes to the high cost drugs and devices list, because for these HRGs we do not hold the data to assess changes to nationally-priced revenue. However, we do hold the data to assess changes to top-ups revenue for these HRGs, and so we have included them in the analysis for this section.

[36] Some providers incorrectly use local payment rules for specialised services. This means that expenditure could be incorrectly attributed between NHSE specialised commissioning and CCGs in some cases.

[37] Prescribed Specialised Services 2015/16 Shadow Monitoring Tool www.hscic.gov.uk/casemix/prescribedspecialisedservices

Our assessment focuses on changes in payment in 2017/18. The assessment accompanying the statutory consultation notice will also cover changes in payment in 2018/19.

6.2. Commissioner impact

Moving from the current policy (SSNDS top-ups, scenario 1) to the PSS top-ups proposed by York (scenario 2) would increase total spending on top-ups by £110 million. This is driven by two factors; the set of services eligible for top-ups (which we discuss below), and the actual top-up rates. Over 750,000 spells of patient care would be eligible for PSS top-up payments, while less than 220,000 are eligible for SSNDS top-up payments. Also, York proposed new top-up rates for all services. **Figure 5** shows total top-up spending under each scenario.

Figure 5: NHS England top-up spending

S1 top-up revenue (£ million)	S2 top-up revenue (£ million)	S3 top-up revenue (£ million)	S4 top-up revenue (£ million)	S5 top-up revenue (£ million)
323	433	416	416	417

Source: NHS Improvement analysis

Scenario 3 (York approach adjusted for currency design change) would cause a smaller increase in top-up spending, of around £93m. This is because HRG4+ phase 3 better reflects the differences in complexity of different operations and therefore reduces the need for top-ups. The total amounts spent on top-up payments in scenarios 3 to 5 are identical as transitioned areas would be compensated by reducing other top-ups by a corresponding amount.

NHS Improvement and NHS England policy is that changes to top-ups should not affect total NHS spending. If spending on top-up payments increases from current levels (in other words, if any of scenarios 2 to 5 is chosen), this will be funded by reducing all prices for admitted patient care slightly, so that total NHS spending stays the same.[38]

6.3. Impact by specialist area

The new PSS top-ups (scenarios 2, 3, 4 and 5) would all increase top-up payments for neurosciences. They would reduce top-up payments for orthopaedics, paediatrics and spinal (although to a lesser extent in scenarios 4 and 5, which attempt to mitigate these reductions). All of these scenarios include four new areas eligible for top-ups: cancer, cardiac, respiratory and ‘other areas’ (mostly comprising GI surgery and urology).

[38] The prices proposed in the tariff engagement document have been reduced in line with scenario 3, 4 or 5 being implemented.

Figure 6 shows a full breakdown of the impact by specialist area.

Figure 6: Top-up revenue by specialist area

Top-up area	S1 top-up revenue (£ million)	S2 top-up revenue (£ million)	S3 top-up revenue (£ million)	S4 top-up revenue (£ million)	S5 top-up revenue (£ million)
Spinal	19	0	0	0	14
Neurosciences	61	139	139	94	88
Orthopaedics	5	2	1	4	4
Children	238	109	106	203	203
Cancer	0	22	22	15	14
Respiratory	0	43	43	29	27
Cardiac	0	107	94	63	59
Other	0	11	12	8	7
All top-up areas	**323**	**433**	**416**	**416**	**417**

6.4. Provider impact

Under all scenarios, over 80% of top-up spending is received by specialist and teaching hospitals. Compared with current SSNDS top-ups (scenario 1), all of the PSS-based scenarios would increase top-up payments to teaching hospitals. The change in top-up payments to specialist hospitals would vary, but under scenario 5 (which NHS Improvement and NHS England consider they are most likely to adopt), payments to specialist hospitals would increase. **Figure 7** shows full details.

Figure 7: Top-up revenue by provider type (£ million)

Provider type	S1 top-up revenue (£ million)	S2 top-up revenue (£ million)	S3 top-up revenue (£ million)	S4 top-up revenue (£ million)	S5 top-up revenue (£ million)
Acute - large	23	60	59	47	47
Acute - medium	1	16	15	13	13
Acute - small	1	3	3	4	4
Acute - specialist	97	81	76	104	106
Acute - teaching	200	272	262	247	247
Total	**323**	**433**	**416**	**416**	**417**

Source: NHS Improvement analysis (Note: Figures may not sum exactly due to rounding)

We recognise that there are ongoing sector concerns about the impact of any transition on key providers. NHS Improvement and NHS England will continue to address these with their stakeholder engagement groups the specialist and complex care policy and technical groups.

We also recognise that there is ongoing work with providers to examine the correct payment for complex care, which is a distinct issue from specialisation but affects many of the same stakeholders. NHS Improvement and NHS England remain committed to reviewing existing policies and potentially developing new policies to address adequate reimbursement of complex patients.

6.5. Impact on patients

The top-up payments proposed in scenario 5 (which NHS Improvement and NHS England currently prefer) are based on independent econometric analysis and an updated set of PSS definitions. We consider that these payments would better reflect the changing composition of specialist care and lead to more cost reflective prices.

7. Locally determined prices

Less than half of spending within the scope of the national tariff is nationally priced. The remainder is covered by local pricing arrangements. In addition, national prices may be adjusted in two ways: local variations and local modifications.[39,40] The national tariff includes rules governing local prices and local variations and our method for the grant or approval of local modifications (collectively referred to as locally determined prices).

NHS Improvement and NHS England propose two changes to the rules governing locally determined prices (and no further changes for 2018/19). Both of these changes relate to mental health. One is to require mental health commissioners and providers to link prices to locally agreed quality measures. The other is to require them to use locally a new payment approach; episode treatment, year of care, capitation, or another appropriate new payment approach. In this section we assess the impact of these proposals.

7.1. Methodology

Mental health payment is subject to local payment agreements; therefore, the distribution of funding is not set nationally. Given this, assessing the proposed rule changes quantitatively would not be practical, nor would it meaningfully reflect the local payment arrangements under which mental health services operate. Instead, we have considered the likely impact of proposed rule changes qualitatively.

7.2. Assessment

We consider that these changes will:

- Help ensure providers and commissioners develop local payment systems for that are transparent, evidence-based and support patient centred care.
- Help to give commissioners, providers and patients clarity on the expected scope of service, the expected quality of care and outcomes for patients.
- Support more effective use of resources within the health service.
- Enable discussions about the value care is providing to patients, and where appropriate, the benefits of investing in mental health care to coordinate care and reduce demand for mental and physical health care in future.

[39] Local variations are where commissioners and providers agree different payment arrangements because they consider this would help them innovate in the design and provision of services.

[40] Local modifications are where providers are paid a higher price because they can demonstrate to NHS Improvement that there are structural reasons why it would be uneconomical for them to provide a service at the national price.

- Cause some additional administration costs to mental health providers and commissioners.

8. Combined impact

While it is important for national tariff stakeholders to understand the impact of each policy proposal individually, we consider it is also important for stakeholders to understand as well as possible how all of the policies, acting together, would affect providers, commissioners and patients.

We do not have sufficient data to fully combine our assessment of the impact of different policies. As we have noted in sections 2 to 7, there are some policies whose impact we cannot fully quantify, and it is difficult to include these policies in a combined assessment.

However, what we can do is assess the combined impact of the two most significant areas of policy change; proposed national prices (Section 2) and changes to top-up payments for specialised services (Section 6). The results of this are described in this section. We have not included independent providers because, while they receive nationally-priced payments, they do not receive top-ups. So we would have nothing to add beyond what is in Section 2. We have also noted our intentions to assess the potential impact on patients with protected characteristics. We anticipate providing a more comprehensive combined assessment in the impact assessment accompanying the statutory consultation.

8.1. Methodology

In this section we combine the analyses we have done on the impacts of the proposed national prices and changes to top-up payments for specialised services.

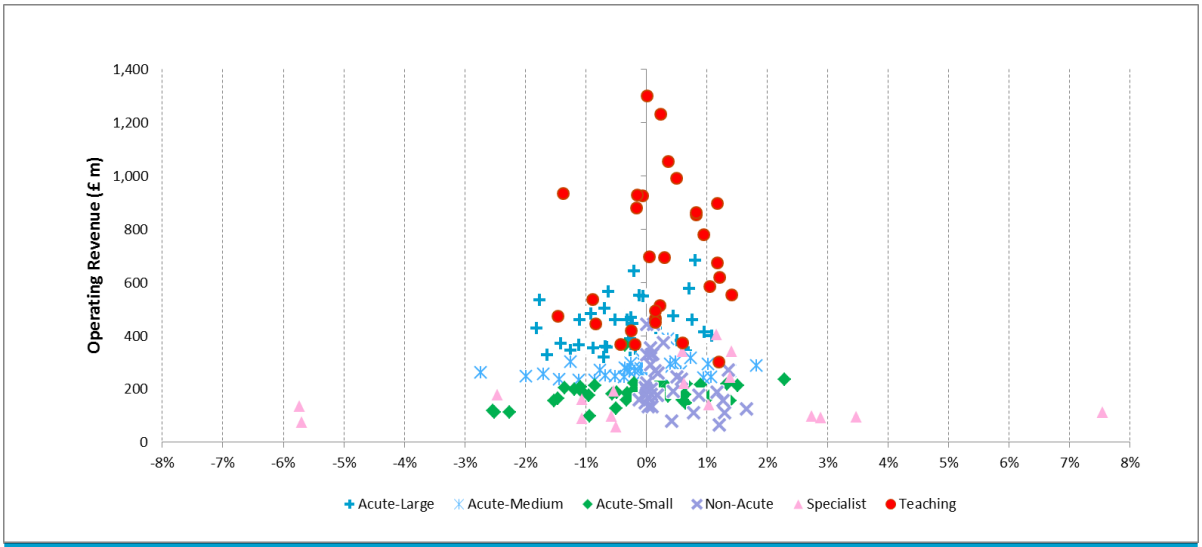
For simplicity, we have focused our analysis on just one top-up scenario (scenario 5), which is described in Section 6 and is NHS Improvement and NHS England's currently-preferred scenario for top-ups.

8.2. NHS providers

For 136 NHS providers (69%), proposed prices combined with top-ups would change operating revenue by less than +/-1%. For 184 NHS providers (94%), they would change operating revenue by less than +/-2%. This is illustrated in **Figures 8** and **9**, which also show that the impact is most varied for specialist trusts:

- Three specialist trusts show the biggest increases in operating revenue (each increasing by over 2.9%, with the highest at 7.6%)
- Two specialist trusts (orthopaedic trusts) have the largest decreases in operating revenue (both decreasing by around 5.7%)

Figure 4: NHS Provider revenue changes



Change in Operating Revenue	Acute - Large	Acute - Medium	Acute - Small	Specialist	Teaching	Non-Acute	All
5% <= x	0	0	0	1	0	0	1
4% <= x < 5%	0	0	0	0	0	0	0
3% <= x < 4%	0	0	0	1	0	0	1
2% <= x < 3%	0	0	1	2	0	0	3
1% <= x < 2%	1	4	4	4	6	7	26
0% <= x < 1%	10	11	12	2	14	27	76
-1% <= x < 0%	18	14	13	3	8	4	60
-2% <= x < -1%	7	5	6	2	2	0	22
-3% <= x < -2%	0	1	3	1	0	0	5
-4% <= x < -3%	0	0	0	0	0	0	0
-5% <= x < -4%	0	0	0	0	0	0	0
x < -5%	0	0	0	2	0	0	2
Sum	36	35	39	18	30	38	196

Source: NHS Improvement analysis

These impacts are largely driven by the changes in national prices, which account for around 80 times as much provider revenue as specialist top-ups.[41] Due to this, our finding are similar to the national prices section. The impact of the new proposed top ups on revenue broadly impacts providers in the same direction as national prices with for example reductions in top up payments for othopedic work occurring under the new proposals. Finally, the new top up areas, such as cardiac top up payments, would naturally only benefit those trusts with a high amount of specialised work in these areas, and broadly this tends to be trusts that were already gaining under the national tariff for example specialised cardiac providers.

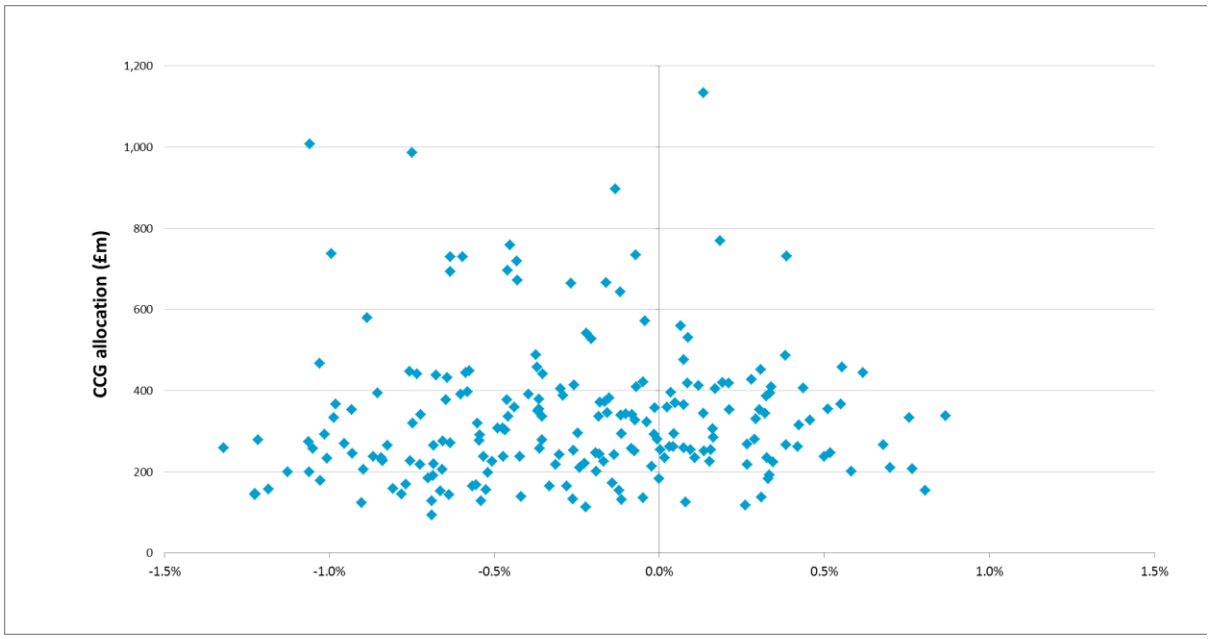
8.3. Commissioners

In total, we estimate that CCG expenditure would fall by approximately £175 million, while NHS England spending would increase by the same amount. **Figure 10** shows changes in CCG spending. This change is mostly driven by the proposed increase in

[41] >£30bn compared with <£500m

specialist top-up spending (approximately £100 million), which would all be paid for by NHS England. It is around 2% of total NHS England commissioning expenditure.[42] For all CCGs, spending would not change by more than +/-1.3%.

Figure 5: Combined impact of proposed price changes and top-ups on Commissioner spending



Source: NHS Improvement analysis

8.4. Patients and Equalities

Any proposals to change national prices potentially impact patients, but this impact is indirect. Draft prices set out the financial incentives facing providers and commissioners. It is how they respond to these incentives (by changing how they provide or commission care) that will determine how draft prices affect patients.

Substantial changes in the prices for services used by patients with characteristics that are protected under the Equality Act 2010 might affect how well we are fulfilling our equalities duties.[43] Once we have further developed our proposed prices, we plan to assess the potential impact of the policies on people with protected characteristics, compared with those who do not share them. This includes the extent to which the proposals may affect the disadvantages suffered by those individuals or the extent to which the NHS services is subject to the payment system addresses their needs. We intend to do this by looking at patient care in the most recent available activity data and comparing their draft price with their current price

[42] NHS England is responsible for commissioning specialised services. In 2015/16, its budget for this was around £14.6 billion.

[43] Equality Act 2010 (The Act) protects people from discrimination on grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, and sexual orientation.

for protected characteristics which we have HES data for.[44] For characteristics that do not have quantifiable data we intend to conduct qualitative analysis.

We are very interested in developing the way we assess the impact of price changes on patients. We would like to make improvements by the time we publish the statutory consultation notice on our proposals for the 2017/19 national tariff. For example, we plan to analyse the distribution of price changes for each different ethnicity, age and gender group. We welcome your views on how we could do so.

9. Patient choice and competition

Our role includes ensuring that procurement, choice and competition operate in the best interests of patients and preventing anti-competitive behaviour in the provision of healthcare services that is not in the interests of patients. This section considers whether the tariff engagement proposals are likely to affect competition in a way that may be detrimental to patients.

For the statutory consultation notice we will set out a comprehensive assessment of the impact of the proposals on patient choice and competition. In this section we describe the methodology we will use.

9.1. Methodology

We will assess the potential effects of the tariff engagement proposals against the competition checklist criteria set out in the Competition and Markets Authority's (CMA) guidelines on competition impact assessments.[45] That is, we will consider whether the proposals are likely to:

- limit the number or range of suppliers directly;
- limit the number or range of suppliers indirectly;
- limit the ability of suppliers to compete;
- reduce suppliers' incentives to compete; or
- limit the choice and information available to consumers.

We will also consider whether the proposals are likely to facilitate anti-competitive behaviour given our role in preventing such behaviour.

Two considerations derived from our duties will guide our assessment:

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[44] Hospital Episode Statistics data contains information on the age, gender and ethnicity of patients.
[45] See CMA 'Competition Impact Assessment' (CMA50), Part 1 (overview) and Part 2 (guidelines), 15 September 2015 at www.gov.uk/government/publications/competition-impact-assessment-guidelines-for-policymakers

- **The role of national prices in facilitating patient choice and competition between providers.** The national tariff regulates prices for most acute healthcare services, and reimburses hospitals according to the number of procedures they carry out. As national prices are fixed, providers cannot compete on price so they compete for patient referrals by increasing the quality of the services they provide. In this way, providers have a financial incentive to make long-term investments and improve the quality and efficiency of their services to attract more patients and consequently higher revenues.

- **That regulated national prices should reflect providers' efficient costs of delivering the relevant services.** How prices are set, and the level at which they are set when compared with the costs of provision, are likely to have significant effects on the incentives on providers and commissioners and therefore on the structure of the market and competition.

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NHS Improvement is the operational name for the organisation that brings together Monitor, NHS Trust Development Authority, Patient Safety, the National Reporting and Learning System, the Advancing Change team and the Intensive Support Teams.

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 Publication code: C 03/16