2019/20 National Tariff Payment System – A consultation notice

Impact assessment

NHS Improvement

January 2019

2019/20 National Tariff Payment System – A consultation notice: Impact assessment

Version number: 1

First published: January 2019

Updated:

Prepared by: NHS Improvement pricing team

Classification: OFFICIAL

This information can be made available in alternative formats upon request. Please contact pricing@improvement.nhs.uk

Contents

Summary

1. This document presents an assessment of the likely impact of the implementation of the proposals of NHS Improvement[1] and NHS England, as set out in the statutory consultation notice on the 2019/20 National Tariff Payment System (the 2019/20 NTPS). It provides a public record of our assessment of the impacts of our proposals, has informed our decisions on the proposals and will help providers and commissioners inform their internal modelling of the financial impact of our policy proposals. It sets out:

   - the rationale for these changes, in conjunction with Part A of the consultation notice
   - an estimate of the aggregated likely impact of these changes on provider revenue and commissioner expenditure to better support financial planning in 2019/20
   - a description, where possible, of their likely impact on patients.

2. This impact assessment should be read alongside the document *2019/20 National Tariff Payment System – A consultation notice*[2] which provides full details of the changes proposed for 2019/20.

3. This impact assessment is issued in exercise of functions conferred on Monitor by Section 69 of the Health and Social Care Act 2012 (the 2012 Act). Therefore, 'NHS Improvement' refers to Monitor, unless the context otherwise requires. References to 'we' and 'our' in this report usually refer to NHS Improvement and NHS England.

4. As required by Sections 69(7) and 118 of the 2012 Act, NHS Improvement is consulting on the proposals which are the subject of this assessment. The consultation period is 28 days, with the closing date being 21 February 2019. For further details of how to respond to the consultation, see Section 3 'Responding to this consultation' in the statutory consultation document.

Scope of analysis

5. In *2019/20 National Tariff Payment System – A consultation notice* we present our proposals for setting final national prices for 2019/20. As set out in Sections

---

1 Since 1 April 2016, Monitor and NHS Trust Development Authority have been operating as a single integrated organisation known as NHS Improvement.

2 Available from: https://improvement.nhs.uk/resources/national-tariff-1920-consultation/

6 and 9 of that document, we propose that acute emergency care and maternity services are no longer in the scope of national prices. However, the unit prices to be used for the acute emergency services payment arrangements and the non-mandatory prices for maternity services have been set using the same process as for national prices. Therefore, references to prices in this impact assessment document include unit prices for acute emergency care and non-mandatory prices for maternity services.

6. Due to the dynamic nature of policy discussions and the timing of policy decisions around funding arrangements and the publication of The NHS Long Term Plan[3] we have been constrained in our ability to model the isolated impacts of individual policy proposals. Therefore, we have presented the impact at an aggregate level, combining all policy proposals. We have not set out the counterfactual for each policy proposal and how they have been assessed. However, we have taken into regard central Government guidance in undertaking Impact Assessments, as set out in Section 69 of the 2012 Act.

7. We use 2016/17 activity levels to present an assessment of the changes in national prices and prices for acute emergency care and maternity services, as set out in the 2019/20 NTPS. However, in using 2016/17 activity levels, we recognise that we do not consider either growth in activity nor changes in the distribution of activity in the period 2016/17 to 2019/20.

8. For the purposes of this assessment, we have assumed for the blended payment approach for acute emergency care, 2016/17 activity levels are used as the activity levels agreed by commissioners and providers. The result of this is that in our modelling, we do not assume any marginal rate payments or deductions of 20% above or below this activity level, and local areas should factor this into any modelling. In the event that actual levels of activity are greater than planned activity levels, provider revenue and commissioner expenditure will be greater than projected in this Impact Assessment, but at a lower incremental rate, as the lower marginal payment (20% of the health resource group) will have then come into effect.

9. The wider circumstances in the NHS are likely to change following the publication of the NHS Long Term Plan. The proposed one-year tariff would give us the opportunity to evaluate the impact of some of our proposals and

[3] Available from: www.longtermplan.nhs.uk/

enable us to respond to changing circumstances in the NHS and ensure the payment system supports the delivery of the NHS Long Term Plan.

Our assessment approach

10. In our financial assessment for providers we measure the impacts by presenting the change in tariff revenue from 2018/19 to 2019/20 as a proportion of 2016/17 operating revenue. We do this to show how changes in tariff revenue affect overall provider revenues. We have used 2016/17 operating revenue as our baseline measure as we have used 2016/17 reference cost data and 2016/17 Hospital Episode Statistics (HES) activity levels as inputs in our method for calculating national prices and prices for acute emergency care and maternity services.

11. Our assessment of the impact on commissioners presents the change in 2018/19 tariff expenditure to 2019/20 tariff expenditure as a proportion of 2019/20 allocations.

12. For the purposes of this assessment, we have grouped the changes into the following three areas:

    - **Updating national prices and prices for acute emergency care and maternity services to reflect the most recent data and currency design.** We calculated the proposed 2019/20 national prices and prices for acute emergency care and maternity services using 2016/17 reference costs data,[4] 2016 /17 HES activity data and the latest version of HRG4+ currency design.
    - **Applying existing policies and adjustments to national prices and prices for acute emergency care and maternity services.** As in previous years, we have adjusted the proposed 2019/20 national prices and acute emergency care and maternity prices based on our established approach to setting the national prices.[5] This includes manual adjustments to reflect expert opinion, price scaling to ensure expenditure fits within the budget envelope, price and revenue smoothing to manage volatility and adjustments to account for expected inflation and efficiency improvements.

---

4 2016/17 reference costs data adjusted to 18/19 levels using the current tariff cost uplift and efficiency factor

5 Our approach for setting national prices is set out in section 11 of the 2019/20 consultation notice document

- **New policies.** The 2019/20 NTPS includes several new policy proposals to incentivise changes in behaviour and support ongoing developments in the healthcare sector.

13. To inform our assessment we have modelled two scenarios. Scenario 1 represents our base run assessment, modelling the impact of changes in national prices and prices for acute emergency care and maternity services, which includes the proposal to transfer £1 billion from the Provider Sustainability Fund (PSF)[6] into acute emergency care prices, funding to cover Commissioning for Quality and Innovation (CQUIN)[7] payments and the Agenda for Change pay awards.

14. Scenario 1 represents the starting point of our analysis and has been conducted for NHS providers, independent providers and commissioners.

15. However, some of our proposals for 2019/20 include transferring revenue streams that currently sit outside the tariff system. Therefore, to ensure we are making like-for-like comparisons between 2019/20 and 2018/19, we have modelled impacts to control for the transfer of funds in scenario 2. Any reference to 'adjusted impacts' should be read as our assessment under scenario 2[8] and is limited to NHS providers. Modelling limitations have meant that further model runs were not possible, and a similar assessment could not be made for commissioner impacts.

Headline findings of combined 2019/20 proposals

16. The new policies we anticipate would have the greatest impact on providers and commissioners include:

- introducing a blended payment approach for acute emergency care, which moves the NTPS away from a pure episodic payment system for non-

---

6 The Provider Sustainability Fund (PSF) is allocated to support and incentivise the sustainable provision of efficient, effective and economic care by NHS trusts and foundation trusts. The general element of the PSF has been allocated primarily to trusts providing acute emergency care, as they remain under the greatest financial and operational pressure. It also includes elements of funding designed to support the sustainability of non-acute services, to support the overall sustainability of the trust sector.

7 The CQUIN scheme is intended to deliver clinical quality improvements and drive transformational change. It makes a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of patient care.

8 This like-for-like adjustment has only been made for NHS providers We have not made any adjustments for independent providers or commissioners.

elective admissions, Accident & Emergency (A&E) attendances and ambulatory emergency care services

- updates to the calculation method and underlying data for the market forces factor (MFF), thereby introducing new MFF values over a five-year period
- changes to the identification rules IRs, hierarchy, and provider eligibility lists for prescribed specialised services (PSS) and a continuation of the transition path for specialist top-up payments that we introduced in 2017/18 and 2018/19
- making all maternity prices non-mandatory, to address a specific issue to do with pricing of public health services and making further changes to the maternity pathway payment system (MPP)
- changes to the financial architecture to transfer £1 billion from the PSF to prices for acute emergency care, raising all prices by 1.25% as a result of the proposed transfer from Commissioning for Quality and Innovation (CQUIN) and incorporating the Agenda for Change (AfC) pay data for 2018/19 and 2019/20 within the cost uplift factor.[9]

17. We set out the headline findings of this comparison in the following sections.

Impact on NHS providers:

- **Scenario 1:** Overall, all but four NHS providers (98% of those included in our assessment) see a positive impact (in absolute terms) on tariff revenue under 2019/20 rules when compared to 2018/19 prices.
- **Scenario 2:** The impacts seen under scenario 1 are driven by money being distributed through prices, rather than alternative mechanisms such as the PSF. When adjusting for these to account for differences in the mechanism through which money is being distributed (ie including PSF, CQUIN and AfC pay), we anticipate the proposals would have a positive impact on 137 NHS providers (74%) and 47 NHS providers (26%) would see a reduction in tariff revenues when compared with 2018/19 prices. Our analysis indicates the proposals to transfer £1 billion of PSF funding to non-elective and A&E prices (acute emergency care) in the tariff and the inclusion of AfC pay data for 2018/19 and 2019/20 are the main drivers of this.

[9] Every year, the efficient cost of providing healthcare changes because of changes in wages, prices and other inputs over which providers have limited control. We therefore make a forward-looking adjustment to the modelled prices to reflect expected cost pressures in future years.

We estimate that for 164 NHS providers (89% of the providers in our analysis), the change in tariff revenue as a proportion of 2016/17 operating revenue, relative to our projections for 2018/19, is likely to be within ±1 % for 2019/20. For 181 NHS providers (98% of the providers in our analysis), the change in tariff revenue is likely to be within ± 2% for 2019/20. For the three remaining NHS providers this change is likely to be within ± 2.5%.

Impact on independent providers

- **Scenario 1:** Considering our base model outputs, for independent providers (at group level), we anticipate there would be a positive impact on tariff related revenue. For four providers (grouped under 'Other'), it is anticipated that there would be an overall reduction in revenue. Our analysis indicates that tariff-related revenue would increase in aggregate by £77 million (5.8%) from 2018/19 levels.

Impact on commissioners

Scenario 1: Our analysis under this scenario (ie the analysis without any adjustments for PSF, etc) indicates that for clinical commissioning groups (CCGs) there would be an increase in tariff expenditure of 5.5% (£1.7 billion) in 2019/20 when compared to 2018/19. For NHS England Specialised Commissioning, tariff expenditure is expected to increase by about 5.6%.

The changes in national prices in 2019/20 are estimated to increase costs to CCGs between +1.30% and +2.8% of 2019/20 CCG allocations. For 77% of CCGs, the increase is +2.0% or more. These estimates are calculated on the basis of no local variations and 2016/17 HES activity.

Impact on patients

- **Scenario 1:** We anticipate that the proposals for 2019/20, which result in extra money flowing through prices, are likely to improve access and quality of care. At minimum, they are likely to ensure access to healthcare and quality of healthcare are maintained as local healthcare providers would be more able to provide sustainable services as prices are more likely to reflect costs.

Impact on patients with protected characteristics

- We anticipate the overall impact of the proposals would be unlikely to be disproportionate on any group with a protected characteristic under the Equalities Act 2010.

Impact on patient choice

18. For the majority of the 2019/20 NTPS, we do not anticipate there would be an adverse impact on patients' ability to exercise choice or provider competition in the market. This is because the proposals apply to all providers and so the impact on patient choice and competition should be minimal. We describe the likely impact of individual policies on patient choice and competition between providers in section 5 of this document.

1. Introduction

1.1. Purpose of the document

19. In the statutory consultation notice on the 2019/20 National Tariff Payment System (NTPS), NHS Improvement and NHS England propose several policy changes. This document presents our assessment of the likely aggregated financial impact of the 2019/20 NTPS proposals on provider revenue and commissioner expenditure compared to the 2018/19, assuming 2016/17 levels of activity. It also explains the rationale for the proposed changes and discusses the likely impact of the proposals on patient care.

20. This document provides a record of our assessment of the likely impact of the proposals in the NTPS, which informs our decisions on the national tariff and aims to help providers and commissioners inform their internal modelling of the financial impact of our policy proposals and make representation to us under the statutory consultation process.

1.2. Our assessment approach

21. The 2019/20 NTPS differs from the 2018/19 NTPS in three main ways;

- We have calculated national prices and prices for acute emergency care and maternity services using more recent activity and cost data.
- We have adjusted these national prices and prices for acute emergency care and maternity services using a similar set of methodologies to previous years.[10]
- We have introduced several new policies that impact on providers and commissioners.

22. We explain the rationale for each of these proposed changes and discuss their likely impact in section 2. Our assessment aims to be proportionate to the scale of the proposed change, level of stakeholder interest and data availability; as a result, the level of analysis we conducted varies from policy to policy.

23. In section 3, we present our quantitative assessment which focuses on estimating the combined effect of our proposals. For proposals not quantitatively assessed, we have undertaken a high level descriptive assessment of

[10] Our method for setting national prices is set out in out in section 11 of the 2019/20 consultation notice.

proposals on patients, providers and commissioners based on the clinical expertise of the National Casemix Office's expert working groups (EWGs). The EWGs consist of clinicians nominated by their professional bodies and royal colleges.

1.3. Scope and assumptions

24. Due to the dynamic nature of policy discussions and the timing of policy decisions around funding arrangements and *NHS Long Term Plan*[11] we have not modelled the isolated impacts of individual policy proposals and have instead presented the impact at an aggregate level, combining all policy proposals. We have not set out the counterfactual for each policy proposal and how they have been assessed. However, we have taken into regard central Government guidance in undertaking Impact Assessments, as set out in Section 69 of the 2012 Act.[12]

25. Our quantitative analysis holds activity levels constant at 2016/17 levels and calculates the impact as a proportion of 2016/17 operating revenue.[13] We know that cost-weighted provider activity has grown by different rates in 2017/18 and we expect this will continue in 2018/19 and 2019/20. This will affect the aggregate impact of the proposed changes on provider revenue and commissioner expenditure.

26. We also assume that providers and commissioners fully comply with the national tariff. Actual activity and compliance levels in 2019/20 may of course differ from these assumptions. This and the use of contract activity levels are simplifying assumptions, to allow a comparison of price changes.

27. We do consider some but not all changes in other revenue streams, eg healthcare funding outside the NTPS, which may influence provider revenue, the impact of our proposals on new business models, plans to move towards more integrated healthcare systems and the Financial Recovery Fund.[14] The

---

[11] Available from: www.longtermplan.nhs.uk/

[12] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/685903/The_Green_Book.pdf

[13] As this was the latest data available when the tariff prices were produced. 2017172017/18 data has since been published

[14] In 2019/20 we will create a new Financial Recovery Fund (FRF) initially of £1.05bn, including £200m transferred from PSF, to support efforts to secure the financial sustainability of essential NHS services, with trusts able to cover current day-to-day running costs whilst they tackle unwarranted variation.

revenue streams considered in our analysis includes the PSF, CQUIN and AfC pay data for 2018/19 and 2019/20.

28. We estimate the aggregate financial impact of all policies on provider revenue and commissioner expenditure rather than estimating the effect of individual policies. We do this as the national tariff brings together several policy proposals that interact to create the overall impact on prices. This document does not identify the degree to which individual policies drive changes in provider revenue.

29. We have included an assessment of the likely impact of our proposals on population groups with protected characteristics. Consultees are invited to provide any comments or information which may assist with any further qualitative or quantitative assessment of impacts in relation to equality.

1.4. Document structure

30. This document supports the s118 statutory consultation notice. It is structured as follows:

- Section 1 sets out the introduction and purpose of the document.
- Section 2 provides the rationale for the 2019/20 NTPS policy proposals set out in the 2019/20 NTPS consultation notice.
- Section 3 presents the aggregate financial estimated impact of the 2019/20 tariff proposals on provider revenue and commissioner expenditure.[15]
- Section 4 considers impact in relation to equality.
- Section 5 considers the likely impact of our proposals on patient choice and competition.
- Section 6 contains the conclusion and next steps.

[15] NHS England specialised commissioning and clinical commissioning groups (CCGs)

2. Proposals for the 2019/20 National Tariff Payment System

31. The section gives an overview of the 2019/20 NTPS proposals and the rationale for change. For this assessment, we have grouped the changes we are proposing into three key areas, as described below.

32. This section duplicates in some areas the content set out in the document *2019/20 National Tariff Payment System – A consultation notice,* to ensure this impact assessment can be easily understood.

2.1. Proposed new prices

33. Our 2019/20 proposals are based on new national prices and prices for acute emergency care and maternity care services calculated using the latest available data, 2016/17 reference costs and Hospital Episode Statistics (HES) and the latest version of health resource group (HRG) HRG4+ phase 3 currency design. The updated national prices and prices for acute emergency care and maternity care services reflect the latest available information on provider costs incurred in treating patients with different levels of complexity, meaning that they should better reflect efficient costs. This would help providers and commissioners to decide the most cost-effective mix of services for their population ('allocative efficiency'). They also give providers a strong incentive to be more cost effective in the delivery of each service ('productive efficiency'). Both factors help to improve access and quality of care for patients.

2.2. Applying existing policies and adjustments to calculated prices

34. As in previous tariffs, we propose to adjust the calculated national prices and prices for acute emergency care and maternity care services based on established methods. These adjustments include the following steps.

2.2.1. Manual adjustments (pre-scaling)

35. We have made manual adjustments to the calculated prices to ensure prices are credible, better reflect the underlying costs of healthcare provision and reduce instances where price relativities are implausible or illogical, eg where prices for HRGs with more complexities are lower than those for HRGs with fewer complexities as this could have a negative impact on patient care and

viability of services. These adjustments are based on stakeholder feedback[16] gathered through consultation with EWGs to get expert determination of our methodology and outputs.

2.2.2. Cost base adjustment

36. We adjust the cost base prior to making forward-looking adjustments for inflation, efficiency and other cost uplifts. We do this to ensure, that prior to making the forward-looking adjustments, the amount allowed through the proposed national tariff (cost base) fits within the overall available funding envelope.

2.2.3. Price smoothing to address volatility (post-scaling)

37. In the 2017/19 NTPS, we moved from the HRG4 to HRG4+ phase 3 currency design. This caused some substantial movements in national prices and prices for acute emergency care and maternity care services, and for orthopaedics, neonatal disorders, chemotherapy and radiotherapy. To mitigate the financial impact and manage volatility for providers, we smoothed this volatility by increasing the prices in these HRG subchapters, and by reducing prices for other HRGs. We propose to make similar adjustments to 2019/20 prices, although we are reducing the amount by which the prices are increased.

2.2.4. Cost uplifts (post scaling)

38. We adjust national prices and prices for acute emergency care and maternity care services upwards by the cost uplift factor to account for expected inflation outside the control of providers in 2019/20. For each tariff period, we estimate the cost adjustment factor based on expected inflation of provider unit costs broken into five categories – pay, drugs, capital, the Clinical Negligence Scheme for Trusts (CNST)[17] and other costs – following a similar methodology to previous years. Our proposed cost uplift factor in 2019/20 is 3.8%.

---

[16] Face-to-face and remote engagement to discuss draft prices and relativities. We collect oral and written feedback from EWGs on draft prices and price relativities throughout the tariff-setting process.

[17] CNST, administered by the NHS Litigation Authority, provides an indemnity to members and their employees in respect of clinical negligence claims. It is funded by contributions paid by member trusts. In the tariff calculation, cost increases associated with CNST payments are targeted at certain prices to take account of cost pressures arising from these contributions.

2.2.5. Efficiency (post scaling)

39. We adjust national prices and prices for acute emergency care and maternity care services downwards by the efficiency factor to account for expected efficiency in 2019/20. The efficiency factor reflects the cost reduction we expect providers to achieve by treating patients at lower cost over time, for example by introducing innovative healthcare pathways, technological changes or better use of the labour force. Our estimate of the level of efficiency that is stretching but achievable is based on evidence of the historical efficiency achieved by the sector. We are proposing an efficiency factor of 1.1%, lower than the 2% efficiency factor applied in previous tariffs. This is supported by analysis of the nine-year efficiency trend in the sector and consideration of other relevant evidence, for example the financial position of the NHS provider sector and external estimates of NHS productivity.

2.3. Proposed new policies

40. In this section, we set out the policies we anticipate would have the greatest impact on provider revenue, commissioner expenditure and patients and our rationale for change. We have not been able to quantitatively assess the impact of individual policies. However, in Section 3 we present the aggregate impact of all the policies discussed here.

2.3.1. Blended payment for emergency care

What are we proposing?

41. We propose to introduce a blended payment approach for emergency care, covering non-elective admissions, A&E attendances and same day/ambulatory emergency care. This proposal is intended to move payments for acute emergency care away from an episodic system to one that combines both a fixed and variable payment. The blended payment approach for emergency care would consist of a payment covering a locally agreed level of activity and a variable payment covering activity above or below this agreed level.

42. This proposed change goes alongside the proposed transfer of £1 billion from PSF to acute emergency care prices to help ensure the overall payments cover the actual costs incurred in providing planned levels of activity. The current marginal rate emergency tariff (MRET) and the 30-day readmission rule would be abolished as national variations.

43. This proposal would have the effect of removing acute emergency care (non-elective prices and A&E prices) from the national prices. Our proposal is that a local pricing framework, which would mandate the use of the HRG prices, would be used to determine the payment covering the locally agreed level of activity.

Why are we proposing this?

44. The proposed blended payment approach aims to encourage providers and commissioners to work more collaboratively and agree ways to use the available resources to manage healthcare demand and provide high-quality, responsive services for patients in the most cost-efficient way.

45. We believe that blended payments would support a more effective approach to resource and capacity planning that focuses on making the most effective and efficient use of resources. A blended payment approach should provide shared incentives for commissioners and providers to reduce avoidable A&E attendances and non-elective admissions by providing the right care in the right place at the right time – and shared financial responsibility for levels of hospital activity.

46. A blended payment approach is also expected to more fairly reflect the costs incurred by efficient hospitals in providing care and provide incentives for continuous improvements in efficiency, minimising transactional burdens and providing space to transform services.

What do we expect the impact will be?

47. In modelling the impact of the blended payment approach for emergency care, we have made the following modelling assumptions:

    - We have used 2016/17 activity to inform the revenue calculations (as with the rest of this impact assessment).

    - We have assumed that the agreed activity levels for non-elective admissions, A&E attendances and same day/ambulatory emergency care associated with the fixed payment are set at the 2016/17 levels for these services.

    - We have assumed that these agreed activity levels were achieved by every provider.

i. We have therefore assumed that no provider receives the variable payment of 20% of the HRG price for activity in excess of the agreed level.

ii. no deductions of 20% of the HRG price are made where activity is below the agreed level of activity.

48. We recognise that these are a highly restrictive set of assumptions. However, they were necessary given the existing pricing model architecture and the limited time available to model the impact of blended payments.

49. The proposed payment approach for emergency care aims to give providers and commissioners greater financial stability, support service transformation and enable more effective allocation of resources. However, there is a risk of protracted contract negotiations where providers and commissioners fail to agree the planned level of activity that informs the fixed payment. To mitigate this risk, we propose the following:

- We will publish national guidance, setting out how the fixed payment should be developed.
- Sustainability and transformation partnerships (STPs)/integrated care systems (ICSs) will be asked to assist providers and commissioners in agreeing the planned level of activity.
- At a local level, further safeguards will be built into the payment system, including the 'break glass' level, which would lead to revised payment arrangements if activity exceeds or falls below pre-determined levels.
- Where no agreement about the planned level of activity can be reached, NHS England/NHS Improvement regional teams will provide support and, where necessary, mediation, taking into account national and local data and information.

50. Our analysis shows the impacts for all policies as a combined effect for 2019/20.

51. In modelling the implementation of the blended payment approach, we have used 2016/17 activity, assumed that the agreed activity levels associated with the fixed payment are set at the 2016/17 levels and that these agreed activity levels are achieved. The implication of this is that no marginal payment/deductions (at 20%) are made against this fixed payment.

What other options did we consider?

52. We considered retaining the existing payment structure for emergency care, including retaining MRET. Based on engagement with commissioners and providers, there was strong support for moving away from the current episodic system and for removing the current MRET arrangements.

53. As part of the payment reform proposals consultation process, an alternative payment structure was considered, whereby a capacity payment would cover the fixed costs of a provider, and a variable payment (equivalent to 20% of the HRG price) would be paid for all activity (and not just the activity above the agreed level). However, following the engagement process, it was agreed not to proceed with this approach.

2.3.2. Updates to the market forces factor

54. We are proposing to update the method for calculating market forces factor (MFF) values and the data we use to ensure providers are more appropriately reimbursed for unavoidable costs and to support both allocative and productive efficiency. We propose to phase in the new values equally over five years to reduce financial volatility in provider revenue.

Why are we proposing to do this?

55. Current MFF values do not accurately account for the differences in unavoidable costs between providers as the data used to calculate the MFF has not been updated since 2010. Externally commissioned[18] analysis found the labour cost differences between London and the rest of England have reduced significantly since the last iteration of the MFF. It is therefore highly likely that some providers have been over reimbursed for the services they provide and others under reimbursed.

What do we think the impact will be?

56. We present our impact of this policy, in combination with the other policies, in section 3. To manage revenue volatility our proposal is to phase in the effect of

[18] Found at: https://improvement.nhs.uk/resources/201920-payment-reform-proposals/#mff

MFF changes equally over a five-year period. For the purposes of our modelling we have included the first year of the five-year phasing.

57. We also present an estimate of the impact of the MFF changes. Overall, we estimate that total MFF-related revenue would increase by around £26 million in 2019/20 when applying the new MFF factors. For 53 NHS providers (29%) we estimate an overall reduction in MFF revenue. In aggregate the reduction in MFF revenue for these providers is estimated to be around £20 million. Of these, the types of provider most affected are likely to be large London teaching or specialist providers accounting for about £8 million of the £20 million reduction.

What other options did we consider?

58. We considered phasing in the impact of new MFF values over a four-year period. However, following publication of draft prices in October 2018, we received quite strong feedback on the impact this would have on financial volatility. We also considered delaying the implementation of the changes, but this option was not desirable as it would mean using out-of-date values for the NTPS.

2.3.3. Moving to a one-year tariff

What are we proposing?

59. We are proposing a one-year tariff.

Why are we proposing to do this?

60. We are proposing significant policy changes in the 2019/20 NTPS such as a blended payment approach for emergency care, updates to MFF values and moving to non-mandatory prices for maternity services. A one-year tariff would enable us to evaluate the impact of these policies and allow us to make further improvements to mitigate any risks or address any unintended consequences.

61. NHS England and NHS Improvement have now published The NHS Long Term Plan, which sets out a range of improvements to the healthcare system over the next five to 10 years. The one-year tariff would give us the opportunity to make initial steps towards supporting the objectives in The Long Term Plan while allowing for the possibility of introducing further changes from 2020/21.

What do we think the impact will be?

62. While multi-year tariffs give providers and commissioners the predictability and financial stability to plan and contract for longer time periods and reduce the administrative burden associated with yearly contracting rounds, we believe that fixing a tariff for a longer period at this stage would limit our ability to respond to changing circumstances in the NHS and address any unintended consequences resulting from the proposed 2019/20 policy changes.

2.3.4. Changes to rules for prescribed specialist services

What are we proposing?

63. We propose to make changes to top-up payments to account for changes in the identification rules, hierarchy and provider eligibility lists for prescribed specialised services (PSS) and to continue implementing the transition path for specialist top-up payments that we introduced in 2017/18 and 2018/19.

Why are we proposing to do this?

64. We want to ensure that the prices reflect the most up-to-date definitions of PSS availability. This includes changes to the PSS identification rules, hierarchy changes and provider eligibility lists. We are also proposing to move to the second stage of the agreed transition path introduced in the 2017/19 NTPS following the move to PSS designation of specialist services. This means that three services losing top-up funding – orthopaedics, paediatrics and spinal surgery services[19] – would see the top-up received reduced by 25%.

What do we think the impact will be?

65. We have not been able to model the isolated impact of changes to prescribed specialist services. We have presented the combined impact of all policies in aggregate in section 3.

[19] Orthopaedics, paediatrics and spinal cord injury services are receiving a lower share of funding as a result of changing the method for calculating top-up payments from top-ups based on the Specialised Services National Definitions Set (SSNDS) to the prescribed specialised Prescribed Specialised Services (PSS) designation of specialist services in 2017/19.

66. The proposed changes to specialist top-ups would make payments for specialised services more cost-reflective and ensure specialist providers are more appropriately reimbursed for care.

2.3.5. Proposed changes to maternity pathway payments

67. We propose to make a number of changes to the maternity pathway payment (MPP) approach.

68. The most significant of these is making all maternity prices non-mandatory.

69. Other proposed changes to the maternity pathway include:

- removing specialist fetal medicine from the scope of the MPP antenatal prices
- changing the payment design and scope of the delivery phase of the maternity payment pathway by:
  - increasing the number of payment levels from two to six
  - setting a separate price for home-based births, based on the 2017/19 'without complications' delivery price
- removing costs of treating women with abnormally invasive placenta (AIP) from the scope of maternity pathway prices
- updating complex factors for the post-natal phase of the MPP and updating the casemix assumptions used to calculate postnatal prices.

70. The full details of proposed changes to maternity pathway payments can be found in section 9 of the 2019/20 consultation notice document.

Why are we proposing to move to non-mandatory prices?

71. We propose to move to non-mandatory prices for maternity services to address a legal issue with the pricing of public health services. Providers and commissioners are strongly encouraged to continue to use the prices as the basis for maternity services payments.

Why are we proposing to remove removing specialist fetal medicine from the scope of MPP prices?

72. The MPP includes costs for specialist fetal medicine activity. Feedback from providers suggests provider-to-provider payments for specialist fetal medicine

referrals create disputes between providers because the cost of providing some specialist fetal medicine services can sometimes be greater than the antenatal tariff price. This often results in specialist fetal medicine providers being under-reimbursed for the care they provide and, in some cases, delays in women being referred for specialist care resulting to poorer patient outcomes.

Why are we proposing to make changes to the delivery phase of the MPP?

73. The current two-payment-level design for the delivery phase of the MPP over-reimburses providers for normal deliveries while under-reimbursing for complex deliveries.

74. The MPP also includes costs for treating women with AIP. This is a rare and dangerous condition affecting around 400 women a year and the cost of treating these women is significantly higher than the current birth tariffs. This leads to providers not being appropriately reimbursed for the costs of treating women with AIP.

75. The proposed changes to the payment levels for the delivery phase of the MPP would, taken on their own, result in significantly lower prices for home births and could disincentivise the provision of home birth services. We therefore propose to set a separate price for home births to encourage the provision of home birth services and improve patient choice.

What is the likely impact of moving to non-mandatory prices?

76. We have modelled the impacts of this policy by estimating the non-mandatory maternity prices through the approach used for estimating national prices and have assumed 100% adherence to these non-mandatory prices.

77. The actual impact of this policy proposal will depend on whether or not providers and commissioners choose to use MPP non-mandatory prices. The impact is likely to be minimal for providers and commissioners that continue to use the prices. If any providers and commissioners decided not to use MPP non-mandatory prices and instead agreed local prices, this could:

    - create an administrative burden for providers and commissioners as they would need to develop a different payment approach

- result in a cost pressure for NHS England public health commissioners if public health services were excluded from the scope of the locally agreed payment approach and needed to be reimbursed separately
- lead to protracted contract negotiations and disputes between providers as they might need to agree provide- to-provider tariffs
- result in providers not being appropriately reimbursed for CNST costs
- make it difficult for providers to deliver non-contracted maternity activity and thereby limit patient choice
- impact on the quality of care and patient outcomes through destabilising the provision of national screening programmes if alternative reimbursement arrangements for public health services were not established.

78. We have modelled the MPP non-mandatory prices to the same standard as national prices to give confidence to local areas that these prices can be used for agreeing prices. We would strongly recommend that providers and commissioners continue to use MPP non-mandatory prices to inform their payment arrangement. We will also provide further guidance for provider-to-provider payments.

What is the likely impact of removing specialist fetal medicine from the scope of MPP prices?

79. This proposal would ensure women have timely access to appropriate specialist fetal medicine care, reduce the number of provider-to-provider disputes and ensure providers are appropriately reimbursed for delivering specialist fetal medicine services. However, it would also result in a small reduction of some tariffs and could in some cases lead to women travelling longer distances. To mitigate this risk, specialist fetal medicine care would be provided through a network hub-and-spoke model with designated specialist fetal medicine providers that also provide clinical support to local obstetricians. This would help to ensure women who need access to specialist fetal medicine input can continue to receive most of their care locally where appropriate.

What is the likely impact of making changes to the delivery phase of the MPP?

80. The proposal to increase payment levels from two to six prices would help ensure providers are more appropriately reimbursed for complex deliveries.

81. The proposal to maintain prices for home births at 2018/19 levels (which would otherwise be lower under our method for determining 2019/20 prices) is likely to encourage the provision of home birth services. This should increase birthing options for women and improve the coding, counting and costing of home deliveries.

82. However, this proposal could have a differential impact on providers and is likely to benefit independent providers that only provide a home birth delivery service. It would also create a cost pressure for commissioners in 2019/20 as they would have to pay providers a higher price for normal deliveries that take place in a home setting. This is because the price for home delivery is being kept at the higher 2018/19 levels. There is also a theoretical risk that it could encourage clinically inappropriate home births, but we do not consider that in practice clinicians will alter their decisions.[20]

83. We also considered moving to 36 payment levels. Although this design would have led to more cost-reflective prices, we were concerned that it would cause financial volatility for providers and commissioners.

What is the likely impact of removing the costs of treating women with abnormally invasive placenta from the scope of MPP prices?

84. This proposal would help support the delivery of care for women with AIP at designated specialist centres from April 2019. This would help to ensure women with AIP can access appropriate specialist care and allow specialist commissioners and providers to work together to improve clinical outcomes for this small cohort of women. Although it would result in a small reduction in the tariffs for Caesarean-section (C-section) deliveries, it would help ensure providers that provide care for women with AIP are appropriately reimbursed. This proposal could potentially lead to some women travelling longer distances to access specialist care, the indirect costs of which would be offset by improvements in the quality of care. The overall impact should be to improve outcomes for women who require more specialised care.

[20] To encourage the provision of home birth services, the price for normal deliveries that take place in a home setting (home births) will be higher than the price of normal deliveries in a hospital setting.

2.3.6. Changes in arrangements for procuring products for the NHS

What are we proposing?

85. We propose to remove around £204 million from the amount allocated to national prices to reflect the proposal to centrally fund the main overhead costs of Supply Chain Coordination Limited (SCCL), a new entity set up by the Department of Health and Social Care (DHSC) as part of its decision to restructure the way in which the NHS procures goods and services. To do this, we propose to apply a downward adjustment to national prices and prices for acute emergency care and maternity services to recover the £204 million.

86. Please refer to Section 8 of the 2019/20 NTPS statutory consultation notice for more details of this proposal.

Why are we proposing to do this?

87. Previously NHS Supply Chain (NHS SC) through an arrangement agreed with DHL, funded its overhead costs through mark-ups charged on product prices. To address the recommendations on unwarranted variations set out in Lord Carter's review on NHS operational productivity, and with the DHL arrangement ending, DHSC took the opportunity to restructure the NHS SC operating model. The new organisation, SCCL, has been set up to increase NHS purchasing power, give providers access to lower procurement prices (potentially removing mark-ups) and drive efficiencies through product rationalisation. We note that SCCL will manage a number of contracts with "Category Tower" providers, who will be responsible for procuring and supplier products to the NHS, as well as contracts for logistics and IT services to support the Supply Chain. The contracts with those providers has been, and will in future be, competitively procured. The contractual payments made by SCCL to those providers accounts for more than 80% of its cost base and a significant proportion of those costs is attributable to improvements to the Supply Chain infrastructure. As part of the new arrangements SCCL would be funded centrally for its costs.

What do we think the impact will be?

88. As with other policies, this Impact Assessment presents the impact of this proposal in combination with other policies in Section 3. The proposed adjustment to national prices and prices for acute emergency care and maternity services is 0.34%.

89. We anticipate the lower product prices offered by SCCL would incentivise more providers to procure products from SCCL. This should, in turn, enable SCCL to increase market share and leverage NHS buying power, give providers access to lower procurement prices and drive efficiencies through product rationalisation, and lead to procurement cost savings for providers using SSCL.

90. Although lowering of tariff prices places a cost pressure on providers, we believe these would be offset by procuring more products through the SCCL and the additional product cost savings that SCCL can deliver. Some providers may not be able to realise these savings immediately because they have commitments with other suppliers that could be costly to exit. For providers that do not use SCCL or do so less than on average, the net effect of the change may be negative because of reduced income as a result of lower tariff prices.

91. The feedback we have received on this policy was strongly in favour of continuing with the mark-up model. However, we consider that the associated investments and expected future savings for users of the service would be at risk without central funding of SCCL's overheads.

92. We also recognise the proposal also places some financial risk on providers. If SCCL were not able to deliver the full savings it expects to generate, providers would not be able to offset (as much as expected) the reduced tariff income through lower product cost and, depending on the extent of the shortfall, could therefore face financial pressures.

93. We have not assessed the impact of the proposals on the market for providers of procurement services like SCCL or suppliers of products into SCCL. This is because the focus of our impact assessment is on how our tariff proposals affect providers of NHS services or patients, rather than the likely impact of the wider NHS Supply Chain model. We note in that context that the overall market size of the services that SCCL provides is relatively small at around 5% of total provider costs and the amount removed from tariff is less than 0.5%. It is therefore unlikely that the proposals would significantly impact on the service offered by providers of NHS services.

2.3.7. High-cost drugs and devices

What are we proposing?

94. We propose to update the high-cost drugs and devices list by:

- removing 58 drugs and adding 107 drugs
- removing one device and adding five devices.

95. The drugs and devices we propose to remove and add to the list are set out in Annex DtA of the 2019/20 NTPS consultation notice.

Why are we proposing to do this?

96. Several high-cost drugs, devices and listed procedures are not reimbursed through national prices because their costs are high and represent a disproportionate cost compared to the expected costs of care within the HRG, and this affects fair reimbursement. These drugs and/or devices are put on the high-cost drugs and devices list and they attract an additional payment. The proposed changes to the high-cost drugs and devices list were informed by feedback from key stakeholders (including the NHS England High Cost Drugs and Devices Steering Group).

What do we think the impact will be?

97. The proposed changes to the high-cost drugs and devices list would help to ensure providers are appropriately reimbursed for extra costs not reflected in national prices and will encourage the adoption of cost-effective innovative drugs and devices. They will also help to improve the quality of care and patient outcomes. However, this proposal could also result in patients not being able to access drugs that have been removed from the high-cost drugs list. To mitigate this risk, we would provide guidance clarifying that the costs of drugs and devices removed from the list are included in national prices.

2.3.8. Best practice tariffs

What are we proposing?

98. We propose to:

- introduce two new best practice tariffs (BPTs) for spinal surgery and emergency laparotomy
- update eight existing BPTs to reflect new data and clinical best practice
- remove the BPT for same day emergency care to support the introduction of the blended payment approach for emergency care.

Why are we proposing a BPT for spinal surgery services?

99. Providers of spinal surgery do not currently submit activity data to a single spinal registry. We are therefore proposing a BPT for spinal surgery services to encourage providers to submit data to the British Spinal Registry (BSR). The data submitted to the BSR supports monitoring of patient outcomes and informs strategies to address variation in clinical practice.

What do we think the impact will be?

100. In our modelling we have assumed 100% compliance with the activities relating to BPTs and have modelled provider revenue accordingly. These impacts are combined with the impacts of other policies in in Section 3.

101. This proposal would have differential impact on providers depending on the systems they currently use. For providers that submit data to the BSR, the impact is likely to be minimal. However, in areas where providers currently submit data to the European Spinal Registry (Spine Tango) and not the British Spinal Registry, this proposal could lead to a slight decrease in income for providers and slight decrease in commissioner expenditure. To mitigate the risk of providers losing income, the BPT price is based on a 50% provider-level case attainment rate for 2019/20 and a 10% differential between the base price and the BPT top-up price.

102. To improve health outcomes, it is recommended that patients undergoing high risk surgery receive consultant-led care in a critical care setting.

What do we think the impact will be?

103. In our modelling we have assumed 100% compliance with the activities relating to and have modelled provider revenue accordingly. These impacts are combined with the impacts of other policies in in section 3.

104. This proposal is likely to lead to a loss of income for providers and decrease in commissioner expenditure in areas where providers do not achieve the BPT criteria. It could also create an administrative burden for providers and commissioners. However, it is likely to lead to improved clinical care and outcomes for patients. We therefore consider the benefits of this BPT to outweigh the costs and risks.

Why are we proposing a BPT for emergency laparotomy?

105. Emergency laparotomy surgery remains a high-risk procedure when compared to elective surgery. Patient outcomes following a surgery vary according to the type of surgery and the setting where it is carried out. We therefore propose a new BPT for emergency laparotomy to increase the proportion of patients whose emergency laparotomy surgery is directly supervised by both a consultant surgeon and a consultant anaesthetist and who are transferred directly to a critical care unit from theatre.

106. BPTs and have modelled provider revenue accordingly. These impacts are combined with the impacts of other policies in in Section 3.

107. This proposal is likely to lead to a loss of income for providers and decrease in commissioner expenditure in areas where providers do not achieve the BPT criteria. It could also create an administrative burden for providers and commissioners. However, it is likely to lead to improved clinical care and outcomes for patients. We therefore consider the benefits of this BPT to outweigh the costs and risks.

Why are we proposing to remove the BPT for same day emergency care?

108. The same day emergency care BPT applies to a limited number of emergency care HRGs. We are therefore proposing to remove this BPT and incorporate the incentive to deliver emergency care within the overall blended payment model for emergency care which covers all aspects of emergency care

What do we think the impact will be?

109. We expect that, by incorporating the incentive to deliver emergency care within the broader blended payment model for emergency care, we would see an increase in the use of same day emergency care by providers. Incorporating this incentive into the broader blended payment would allow commissioners and providers to plan and reimburse emergency care more effectively

Why are we proposing to update existing BPTs?

110. We propose to update the following existing BPTs to reflect new data or clinical best practice:

    - acute stroke

- day-case procedures
- early inflammatory arthritis
- major trauma
- paediatric diabetes
- primary hip and knee replacement outcomes
- rapid colorectal diagnostic pathway (straight to test (STT))
- paediatric epilepsy.

111. The full details of the proposed updates to existing BPTs are provided in Section 10.5.2 of the national consultation document.

112. The existing emergency-related BPTs would continue to apply within the broader blended payment approach.

What do we think the impact will be?

113. We anticipate the proposed updates to existing BPTs would further incentivise providers to deliver best practice. However, they could create an additional administrative burden for both providers and commissioners. There is also a risk that providers are unable to meet target best practice success rates and, therefore lose revenue.

114. The emergency-related BPTs would be incorporated within the fixed payment of the blended payment approach for emergency care. For the purposes of the impact assessment modelling in Section 3, we have assumed that the agreed level of activity associated with the relevant BPTs corresponds with the 2016/17 activity levels and that all relevant providers deliver activity at this agreed level.

2.3.9. Non-mandatory prices

115. Non-mandatory prices are intended to inform local negotiation under the local payment rules. They give providers and commissioners a guide for setting local prices and subsequently can help reduce regulatory and administrative burden.

116. Sometimes non-mandatory prices are produced where we do not have appropriate information (such as reference cost data) to set national prices, but a benchmark price would be a useful starting point for local price-setting discussions. In the document *Non-mandatory prices and currencies*, we have made clear the sources used for each of the prices, and where we expect them to be treated as a benchmark price.

What are we proposing?

117. We propose to introduce new non-mandatory prices for the following services:

- non-face-to-face and non-consultant-led outpatient attendances
- advice and guidance services
- Improving Access to Psychological Therapies (IAPT) services
- in vitro fertilisation (IVF) services
- specialist rehabilitation
- tobacco dependency services
- wheelchair services
- renal transplantation.

118. See the supporting document *Non-mandatory prices and currencies* for details.

Why are we proposing to introduce non-mandatory prices?

119. Currently, we do not have national prices for the activity for which we are proposing non-mandatory prices. We therefore propose non-mandatory prices to enable testing as part of the development of potential national prices and/or to offer the service a guide (benchmark) price to be used as a starting point in local price setting.

What is the likely impact of introducing non-mandatory prices?

120. Introducing non-mandatory prices based on up-to-date data and a consistent calculation methodology gives providers and commissioners a guide for setting local prices and subsequently can help reduce regulatory and administrative burden. This is because non-mandatory prices can help inform the process of agreeing a local price.

121. The proposed non-mandatory prices for non-face-to-face follow-up attendances and non-consultant-led outpatient attendances could encourage the provision of such activity where clinically appropriate. This could help to free up clinical capacity and improve patient access to outpatient services. The financial impact of implementing the non-mandatory prices for non-face-to-face and non-consultant-led outpatient attendances would vary for both providers and commissioners, depending on whether the current reimbursement levels for non-face-to-face and non-consultant-led activity are higher or lower than the

proposed non-mandatory prices. To mitigate the financial impact and risk of destabilising service provision, providers and commissioners could agree local transitional arrangements. The proposed non-face-to-face activity could increase the provision of non-face-to-face services and this could have differential impacts on some patient groups eg age and disability. To mitigate this potential impact, providers and commissioners should ensure they take into account the needs of different patient groups when designing services.

122. For outpatient attendances, we also considered a non-episodic payment to encourage providers to adopt innovative and more efficient ways of delivering care to reduce costs and maximise profits. However, this type of payment could theoretically give a financial incentive for providers to restrict patient access and reduce the quality of care. Another option we considered was a single price across for all settings to incentivise providers to increase non-face-to-face and non-consultant-led attendances where clinically appropriate. Although this would reduce the costs of delivering care in the long term, a single price for both consultant-led and non-consultant-led activity would be likely to under-reimburse providers for consultant-led activity while over-reimbursing them for non-consultant-led activity. We consider the costs and risks of this option to outweigh the benefits.

2.3.10. Locally determined prices

123. Over half of the £76 billion of NHS activity covered by the national tariff is subject to local pricing arrangements.[21] The NTPS includes rules that govern local price setting, including local variations and local modifications. The current rules are set out in Section 6 of the 2017/19 NTPS.[22]

124. Under local pricing rules, national prices may be adjusted in two ways: local variations and local modifications.[23,24.]

[21] Prices for maternity services and emergency care are no longer national prices, but instead are now non-mandatory prices, or are subject to local pricing rules.
[22] https://improvement.nhs.uk/resources/national-tariff-1719/
[23] 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.
[24] 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.

What are we proposing?

125. We propose to make the following changes to local pricing rules:

- Change the local pricing Rule 7 for mental health services to make a blended payment the default payment approach for adult mental health services ((see Section 13.1.1 of the national consultation for details of the proposal).
- Change the local pricing Rule 5 for high-cost drugs, devices and listed procedures (see Section 13.1.2 of the national consultation for details of the proposal).

Why are we proposing changes to local pricing rules?

126. We consider the proposed changes to local payment rules would make them easier to understand.

What is the likely impact of making changes to local pricing rules?

127. A blended payment approach for adult mental health services would help to ensure providers of mental health services are more appropriately reimbursed for the services they provider; support the delivery of integrated care and policy objectives for ICSs; and improve the reporting, recording and costing of mental health activity for working age adults and older people. This proposal is likely to improve the quality of activity and cost data for mental health services and support improved outcomes for patients.

3. Anticipated Impact of all proposals

128. This section presents the overall impacts of introducing new national prices and new prices for acute emergency care and maternity services, making changes to existing policies and introducing new policies. As set out in Sections 1 and 2 of this document, our impacts have been modelled on the basis of combining policy proposals and aggregating their effect on national prices and prices for acute emergency care and maternity services.

129. We start this section by discussing the outputs of our base model run (scenario 1) which simulates tariff revenues for 2018/19 and 2019/20 using 2016/17 HES activity data. The 2019/20 NTPS includes proposals to transfer revenue streams that currently sit outside the tariff system (ie PSF, CQUIN and AfC pay awards) into national prices and prices for acute emergency care and maternity services. We have therefore adjusted the aggregated provider outputs (scenario 2) seen under scenario 1 to reflect that these funding streams are paid directly to providers in 2018/19. Doing so ensures we correctly capture provider impacts on a like-for-like basis and show fair comparisons between 2019/20 and 2018/19. Any reference in this section to 'adjusted' should be read as our like-for-like assessment under scenario 2.

130. Below we set out the adjustments made under scenario 2 of our assessment:

- For each NHS provider included in our assessment, we add their 2018/19 PSF allocation to their simulated 2018/19 tariff revenue as modelled under scenario 1.

- For each NHS provider included in our assessment, we add their proposed/draft 2019/20 PSF allocation (after transferring £1 billion into prices for acute emergency care, ie for non-elective admissions and A&E attendances) to their simulated 2019/20 tariff revenue as modelled under scenario 1.

- For each NHS provider included in our assessment, we add the amount estimated to be received for AfC pay awards via DHSC, adjusted to reflect the amount relating to tariff revenue. We use each provider's tariff revenue for 2019/20 as a percentage of 2016/17 operating revenue as a proxy for the amount relating to tariff revenue.

- For all providers included in our assessment, we inflate 2018/19 tariff revenue by 1.25% to reflect the amount of CQUIN funding received. We assume that all providers receive the full 1.25% funding for 2018/19 and 2019/20.

131. Due to modelling constraints it has not been possible to reflect similar adjustments for commissioner expenditure under scenario 2. Therefore, our analysis for commissioners reflects our analysis under scenario 1. However, for commissioners the analysis under scenario 1 is more comparable than under scenario 2 as PSF does not affect commissioner allocations as it is paid through other central funding.

3.1. Anticipated aggregate impact of all proposals that have been quantitatively assessed

132. Scenario 1 shows large positive year-on-year changes in tariff revenue for providers. Changes in tariff revenue as a proportion of operating revenue range between -0.02% and +4.6% for NHS providers.

133. For 2019/20, changes in national prices and prices for acute emergency care and maternity services are estimated to increase tariff--related expenditure to CCGs by between +1.30% and +2.8% of 2019/20 CCG allocations. For 77% of CCGs, the estimated increase is +2.0% or more.

3.1.1. Anticipated financial impact of 2019/20 NTPS proposals for NHS providers

Scenario 1 analysis

134. Figure 1 below shows the combined impact of our proposals for 2019/20 on tariff revenue for NHS providers ie It reflects the effects of changes in national prices and prices for acute emergency care and maternity services only.

135. The main drivers for this change are the proposals to transfer £1 billion of PSF into prices for acute emergency care services, the increase in the cost uplift factor resulting from the proposal to fund the AfC pay award through the national tariff, and the inclusion of 1.25% of CQUIN. For 67% of NHS providers included in our assessment, they are likely to see changes in tariff revenue in 2019/20 of between +2% and +4% (as a proportion of 2016/17 operating revenue). Most large acute providers are within this range of impacts.

136. Our analysis suggests that, for non-acute providers, 2019/20 NTPS proposals are likely to have minimal impact (no change to around +1.5%) on tariff revenue. This is because local pricing arrangements are likely to have a far greater impact on revenue and our assessment does not quantify the impact this. Additionally, the proposal to transfer £1 billion of PSF into prices for acute emergency care are targeted to non-elective and A&E activity. These services are unlikely to be in scope for most non-acute providers. Our analysis estimates that non-acute providers receive about £11 million of the £1 billion transferring into prices. Furthermore, the NHS Long Term Plan sets out an income guarantee for Mental Health services such that income for Mental Health providers will grow faster than the overall NHS budget.[25]

137. Specialist and teaching providers' impacts are more widely spread than other types of providers. For specialist providers, impacts range from no change to about 3.8%; for teaching providers, they range from about +1% to +4%.

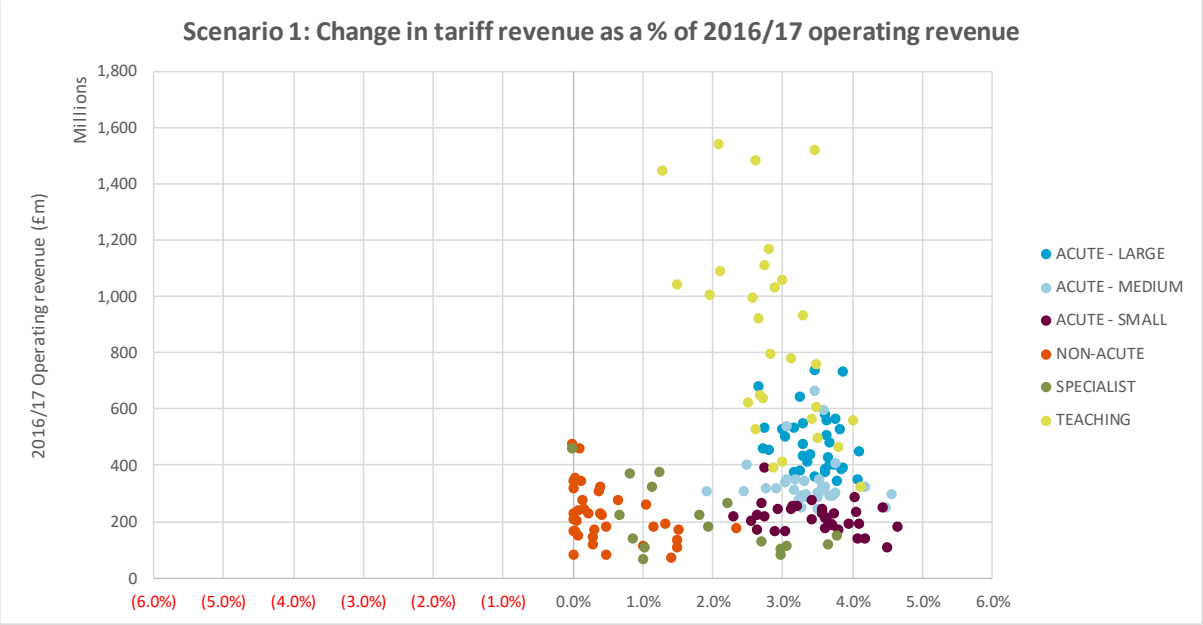
138. The main driver for this spread in specialist providers is the distribution effect of transferring £1 billion of PSF into prices for non-elective, A&E services. Our modelling and analysis estimates that specialist providers would receive about £19 million of the £1 billion transferring into prices for acute emergency care.

139. For teaching providers, our modelling and analysis estimates that they are likely to receive about £324 million of the £1 billion transferring into prices for acute emergency care. However, some of the effects of this are minimised by other policy changes including changes to the maternity prices that result in teaching providers seeing an overall reduction in tariff revenue of about £32 million.

140. Overall, across all types of providers, maternity services are likely to see a reduction in tariff revenue of about £103 million from 2018/19 levels. This is largely due to the proposed reduction in CNST payments to recover an over-reimbursement of CNST costs in 2018/19. The impact of this would be mitigated through the process of setting control totals for 2019/20.

[25] The Long Term Plan makes a renewed commitment that mental health services will grow faster than the overall NHS budget, creating a new ringfenced local investment fund worth at least £2.3 billion a year by 2023/24. This will enable further service expansion and faster access to community and crisis mental health services for both adults and particularly children and young people.

Figure 1: Impact of 2019/20 NTPS proposals on NHS provider tariff revenue (ie what a provider would receive in 2019/20 using proposed new prices, compared to 2018/19), based on 2016/17 activity (scenario 1)[26]



Scenario 2 analysis

141. As discussed in the introduction to this section, our analysis under scenario 1 includes proposals to include funding that was previously excluded from the NTPS. The specific proposals we are including in the 2019/20 NTPS include:

- transferring £1 billion from PSF into non-elective, A&E and same day/ambulatory emergency care and A&E prices
- increasing the cost uplift factor by 1.25% as a result of the proposed transfer of funding from CQUIN
- AfC pay awards using pay data for 2018/19 and 2019/20 through the cost uplift factor.

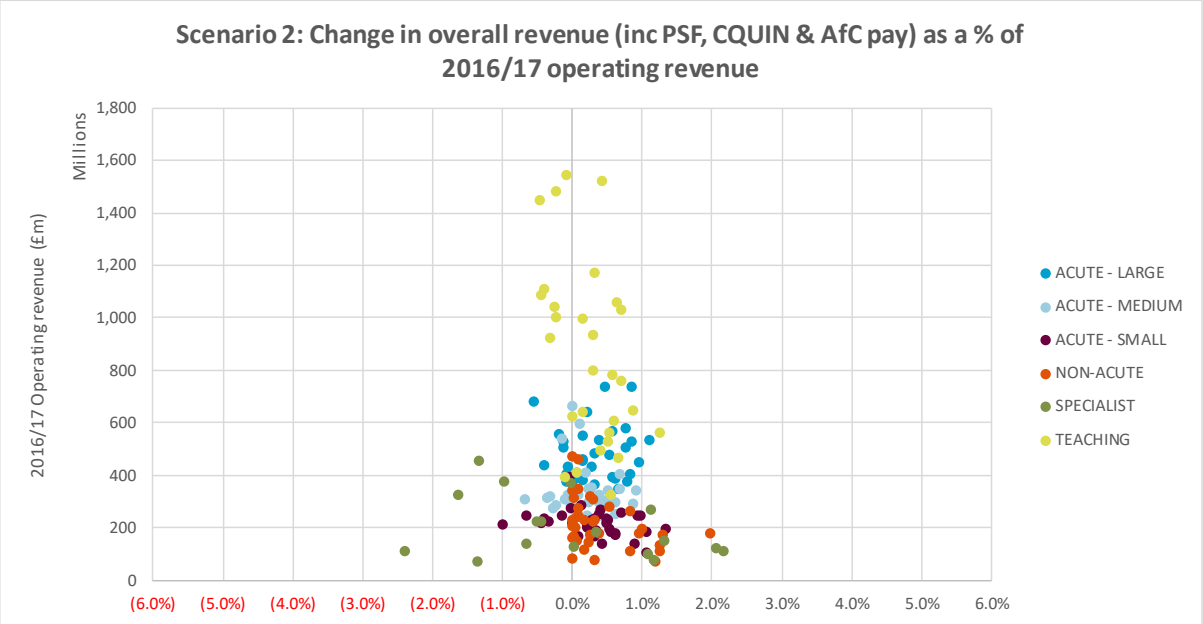
142. Figure 2 below illustrates on average, the estimated change in NHS provider revenue is +0.3% revenues would change under scenario 2. Adjusting tariff revenues for 2018/19 and 2019/20 to account more accurately for other funding streams outside the tariff leads to a shift in provider revenues. The scatter shows that non-acute providers appear to be least impacted by our proposals to

[26] Please note: this figure only shows the impact on tariff revenue. The Long Term Plan guarantees that funding for mental health with grow faster than the overall NHS budget.

transfer £1 billion of PSF into prices for acute emergency care, include CQUIN of 1.25% and account for AfC pay awards through the cost uplift factor.

143. The adjustments to reflect non-tariff revenues are likely to cause the spread of NHS providers to narrow and shift towards the centre. We estimate that 89% of NHS providers fall within ±1% (164 NHS providers included in our assessment) and that, for 98% of NHS providers, impacts are likely to be within ±2% (181 NHS providers included in our assessment).

Figure 2: Overall impact of 2019/20 NTPS proposals on tariff revenue for NHS providers (scenario 2)

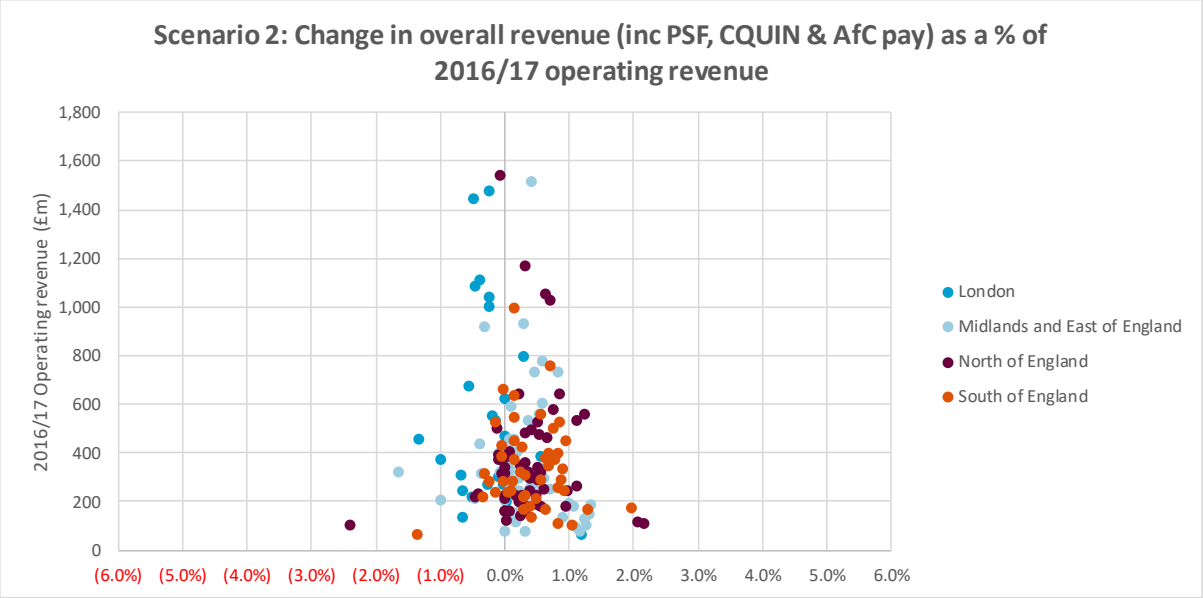


within +/-1%	164	89%
> 1% loss	4	2%
> 1% gain	16	9%
within +/-2%	181	98%

Scenario 2 analysis by region

144. Figure 3 below shows the aggregated impact of the adjusted revenues on NHS providers by region (as at the time of the analysis). Based on our analysis, we expect the 2019/20 proposals to have the greatest impact on London providers. Some of this change is would be driven by the proposed changes to MFF values.

Figure 3: Scatter of NHS provider impacts by region (scenario 2)

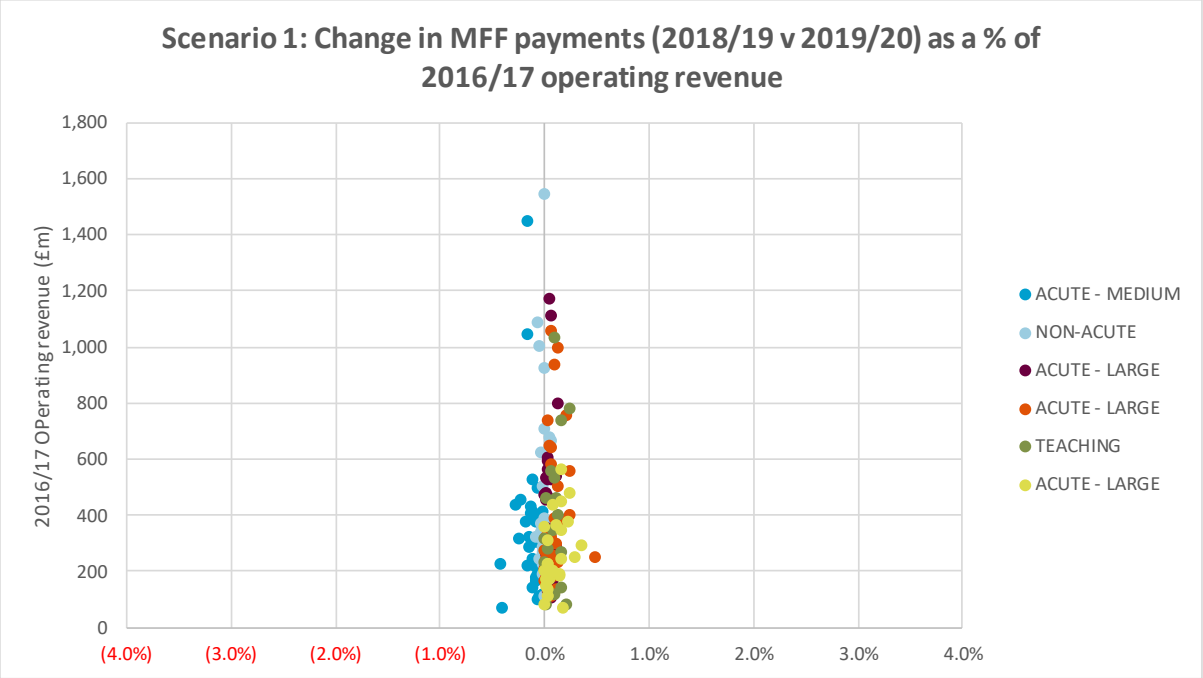


Scenario 1 analysis of changes in MFF revenue

145. Below is a scatter plot (Figure 4) showing the estimated impact of the new MFF values, based upon scenario 1, ie the unadjusted provider revenues. We do this by comparing the MFF payment quantum for 2018/19, which applies current MFF values, with the 2019/20 payment quantum applying new MFF values. The MFF values included in our simulated payment model for 2019/20 are the first year of an equal five-year glidepath (difference between the current and new MFF value for each provider phased in over five equal steps to enable a smooth transition and mitigate large variations from one year to the next).

146. Our analysis suggests that the spread caused by new MFF values is around ±0.5%. It is estimated that 53 of the 184 NHS providers would see a small reduction in MFF payments. For the majority, the interaction of MFF with new policies would likely result in 131 NHS providers (71% of NHS providers included in our assessment) seeing an increase in MFF payments.

Figure 4: Scatter of NHS provider impacts for MFF payment (scenario 1)

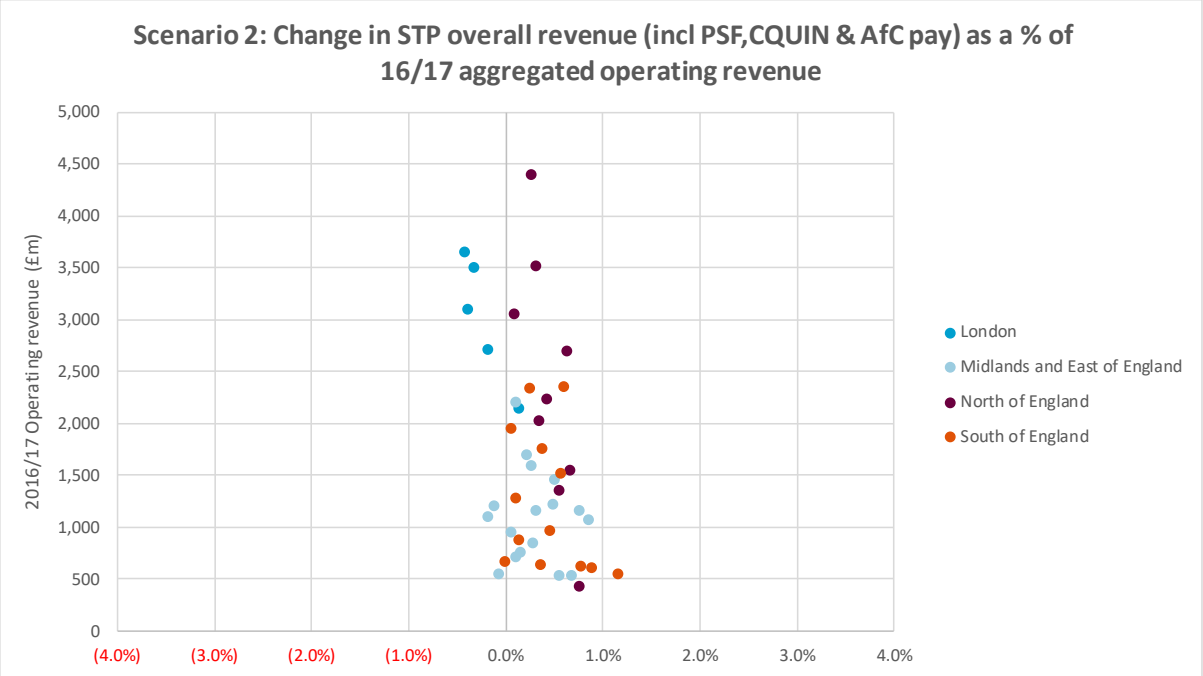


Scenario 2 analysis by sustainability and transformation partnerships

147. Below we show NHS provider impacts aggregated to STP level. To do this, we mapped providers to the STP to which they belong and aggregated operating revenue, simulated tariff revenue for 2018/19 and adjusted simulated tariff revenue for 2019/20. We then calculated the change in tariff revenue between 2018/19 and 2019/20 as a proportion of aggregated operating revenue.

148. Our analysis shows the change in aggregated tariff revenue as a proportion of aggregated operating revenue to be between -0.4% and +1.2%. See Figure 5 below.

Figure 5: Scatter of NHS provider impacts by STP (scenario 2)



3.1.2. Anticipated impact of 2019/20 NTPS proposals by type of provider

149. We also assessed the likely financial impact of the 2019/20 NTPS proposals by type of provider. Scenario 2 outputs show that large acute providers are likely to see the biggest increase in revenue, roughly £68 million (+0.6% increase from 2018/19 and roughly +0.4% as a proportion of aggregated 2016/17 operating revenue)[27] as shown in Figure 6 below.

150. The main drivers for this change are the proposals to transfer £1 billion of PSF funding into prices for acute emergency care and the proposed changes to the cost uplift factor which include AfC pay awards currently funded directly through DHSC.

[27] Total operating revenue when adding all operating revenue figures for each type of provider

Figure 6: Anticipated financial impact of adjusted revenues by type of provider (scenario 2)

Type of provider	2016/17 Operating revenue (£m)	2018/19 Total Tariff Revenue (£m)	2019/20 Total Tariff Revenue (£m)	Tariff revenue difference (£m)	Tariff Revenue difference (%)	Tariff revenue change as % of 2016/17 operating revenue
ACUTE - LARGE	16,900	11,021	11,089	68	0.6%	0.4%
ACUTE - MEDIUM	11,052	7,317	7,337	20	0.3%	0.2%
ACUTE - SMALL	7,862	5,154	5,184	30	0.6%	0.4%
NON-ACUTE	7,944	282	307	25	8.7%	0.3%
SPECIALIST	3,438	1,461	1,452	(9)	(0.6%)	(0.3%)
TEACHING	24,253	12,943	12,962	19	0.1%	0.1%
NHS total	**71,450**	**38,178**	**38,332**	**153**	**0.4%**	**0.2%**
INDEPENDENT TRUSTS	**0**	**1,346**	**1,406**	**60**	**4.5%**	**0.0%**

151. Figure 7 below shows the changes in provider revenues under scenario 1, by type of provider and point of delivery. Our analysis indicates that core inlier payments (driven mostly by the transfer of £1 billion PSF into non-elective prices) and A&E payments see the largest change year-on-year. It is expected that teaching and large/medium acute providers would benefit most from the inclusion of this PSF money in prices for acute emergency care.

152. Given the changes in the MFF, our proposals for maternity services together with proposed changes in the MFF would likely to result in overall maternity income reducing by about £103 million. This change would be driven by the proposed reduction in CNST payments to recover an over-reimbursement of CNST costs in 2018/19. The type of providers most affected are likely to be teaching hospital and large/medium acute hospitals.

Figure 7: Anticipated financial impact of adjusted tariff revenues by type of provider and point of delivery (scenario 1)

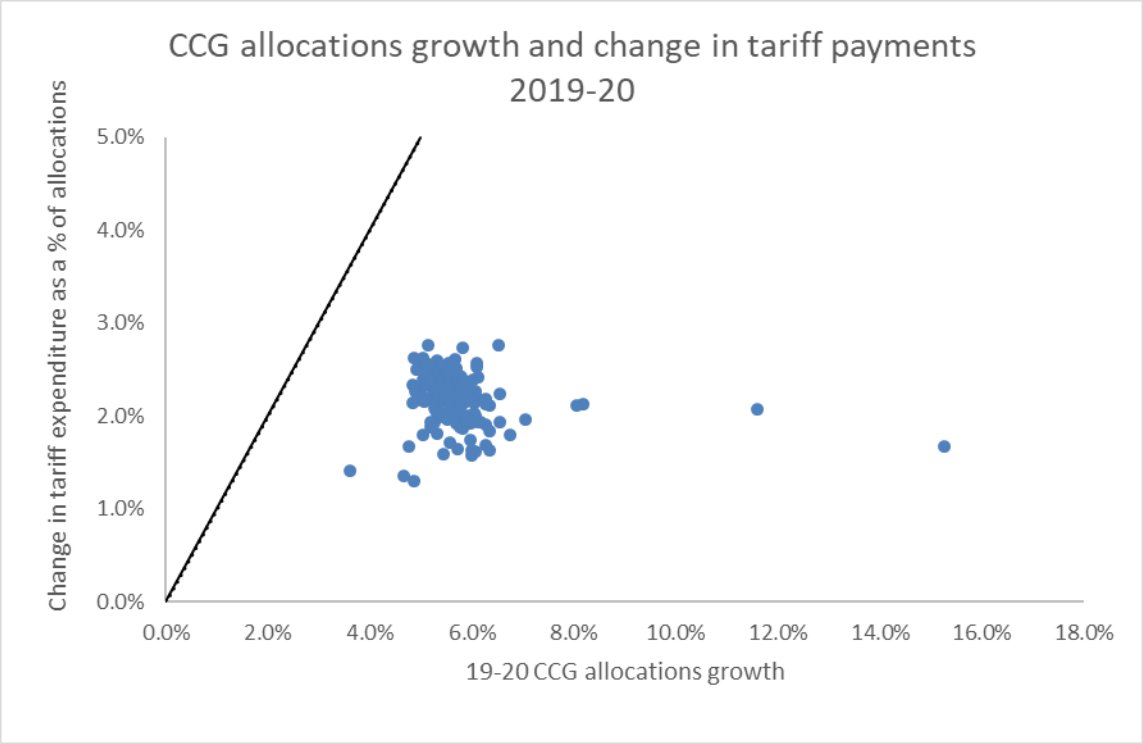
Difference by point of delivery (£m)	ACUTE - LARGE	ACUTE - MEDIUM	ACUTE - SMALL	NON-ACUTE	SPECIALIST	TEACHING	INDEPENDENT TRUSTS	Grand Total
Core payment	356	235	168	9	26	364	53	1,212
Excess Bed Days	58	38	32	11	5	66	2	212
Top Ups	7	(0)	0	(0)	2	48	(0)	56
Outpatient attendance	65	44	29	1	15	73	15	242
A&E	109	72	56	10	5	98	8	358
Maternity	(30)	(22)	(17)	(0)	(2)	(32)	0	(104)
Renal	10	2	1	0	0	19	0	32
Unbundled Diagnostic Imaging	(4)	(6)	(3)	(0)	0	(4)	0	(18)
Unbundled	(3)	(2)	(2)	0	(1)	(3)	0	(11)
Outpatient procedures	12	11	6	1	2	22	(1)	53
Total	**580**	**371**	**270**	**31**	**51**	**651**	**77**	**2,032**

3.1.3. Anticipated financial impact of 2019/20 NTPS proposals on commissioner expenditure based on scenario 1

153. Based on scenario 1, ie provider revenues unadjusted for PSF, CQUIN and AfC pay, we anticipate that, for all CCGs, funding allocations would grow by more than the change in tariff-related expenditure when measured as a proportion of allocations. Changes in tariff-related expenditure as a proportion of 2019/20 allocations are estimated to be greater than +2% for 152 of the 192 CCGs (79% of those included in our analysis).

154. The increases need to be seen in the context of the growth in CCG allocations in 2019/20, which is 3.6% or more. Figure 8 below shows the percentage increase in allocations on the horizontal axis (x-axis) and the percentage change in tariff expenditure (national prices, prices for acute emergency care and maternity services and MFF values) as a percentage of 2019/20 allocations on the vertical axis (y-axis). The line which equates the increase in allocations to the increase in tariff expenditure as a proportion of the allocation is also included, showing the increase in allocations is higher for all CCGs than the impact of the national tariff changes. The growth in CCG allocations takes into account the move of PSF funding into prices, moving 1.25% of CQUIN funding and the AfC uplifts.

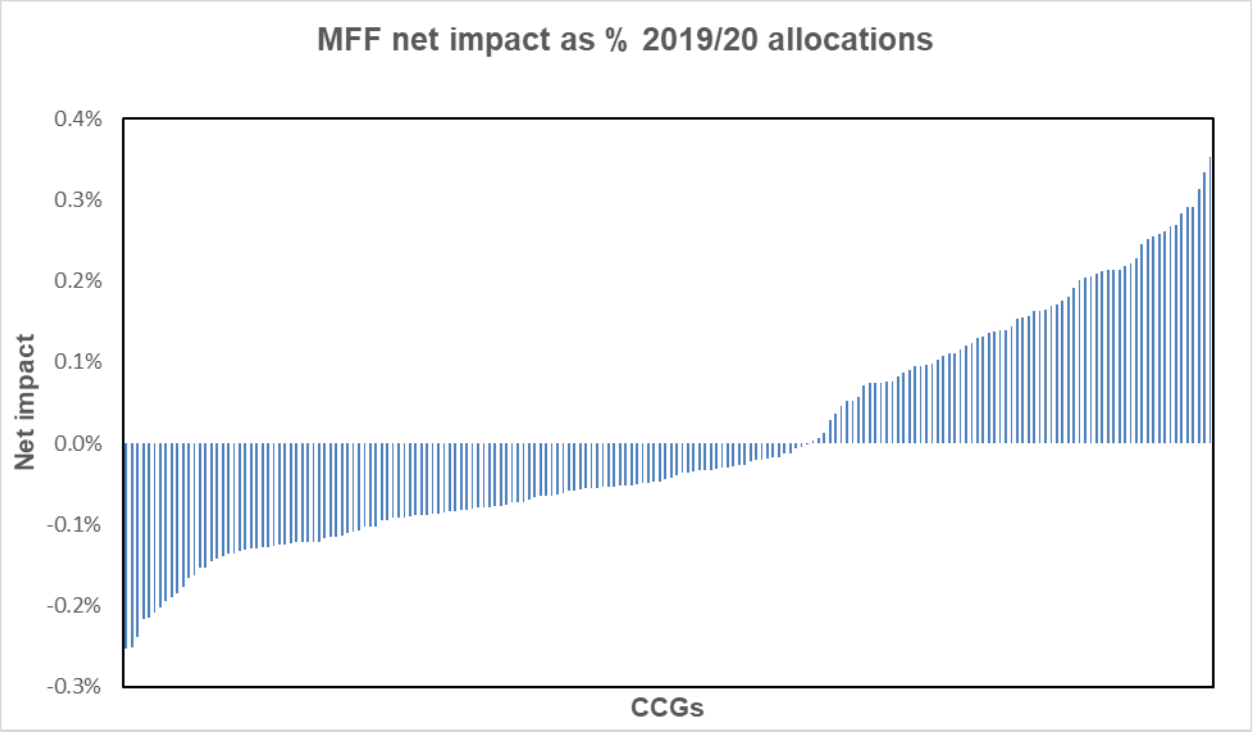
Figure 8: Change in allocation growth and change in tariff expenditure (scenario 1)



155. CCG allocations are driven by a needs-based formula and fund a wider range of services (such as primary care, mental health and community services) and do not have a direct one-to-one relationship with the impact of the tariff changes. The needs-based formula, which changes over time to reflect differential population growth, demographics and morbidity, determines target allocations. Actual allocations are set by pace of change policy, ie how far each year CCGs are moved closer towards their target allocations by differential growth in allocations between CCGs.

156. The target formula includes the MFF. Figure 9 below illustrates the net impact of the MFF changes to CCGs. It estimates the change in allocations due to the MFF alone, compared with the change in payments to providers due to the new MFF. For 73 CCGs (38%) we anticipate these providers would see allocations grow to a level that exceeds the net costs of moving to new MFF values.

Figure 9: Change in allocation growth and change in tariff expenditure



157. The CCG target allocations for 2019/20 have used the new MFF values for 2019/20. The impact is estimated to change target allocations by between -0.8% and +0.5%. After the pace of change policy, the impact of the new MFF is estimated to change actual CCG allocations by between -0.4% and +0.3%.

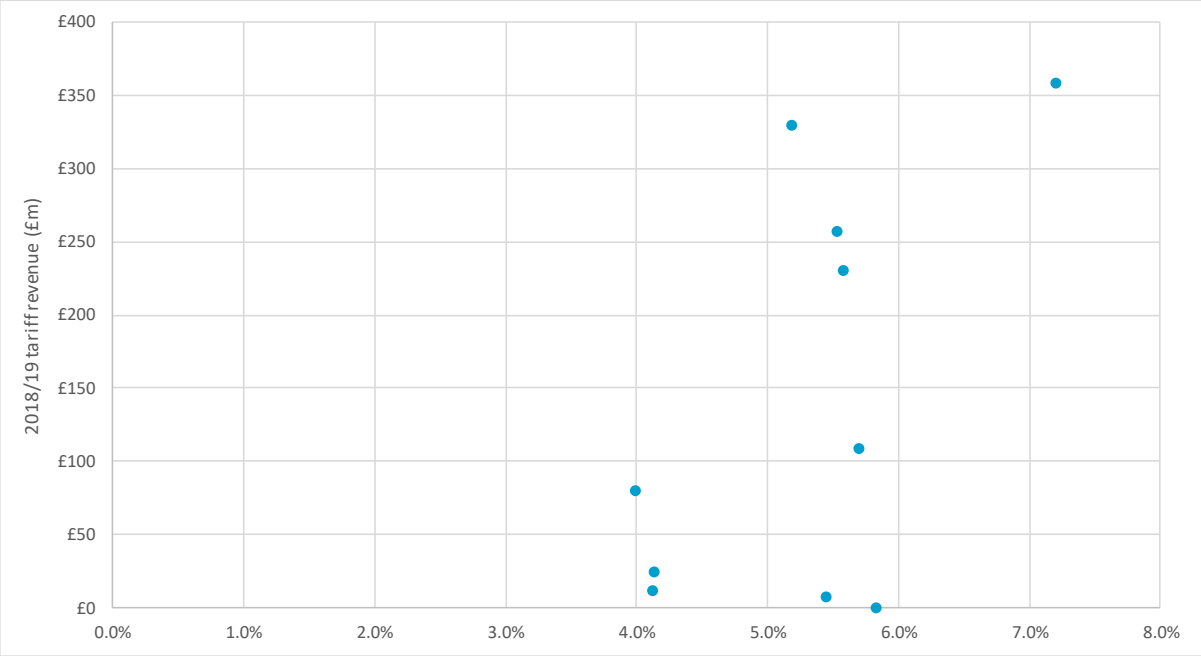
158. The estimated net impact of the new MFF values is the difference between the change in actual allocations and the change in the payments to providers as a result of the changes in the MFF values. This is shown in Figure 9 (above), expressed as a percentage of 2019//20 allocations. The impact is between -0.25% and +0.35% of allocations. This needs to be seen in the context of the increases in total allocations noted above.

159. Based on our modelling, the projected share of NHS England specialised commissioning expenditure is roughly 14% of the total commissioning expenditure in 2018/19 and 2019/20.

3.1.4. Anticipated impact of 2019/20 NTPS proposals for independent providers

160. Our analysis of the base run model outputs (scenario 1) for independent providers indicates that changes in tariff revenue as a result of 2019/20 NTPS proposals are likely to be between +4% and +7.2%. Where possible we have grouped individual hospitals according to ownership. Where this has not been possible we have included these providers in a group titled ‘Other’, which is the extreme outlier at 7.2% in Figure 10 below.

Figure 10: Change in tariff revenue grouped for independent providers as a percentage of 2018/19 tariff revenue



161. Figure 11 below shows the impact on independent providers at hospital level. Overall, we anticipate changes in tariff revenue (change in proportion to

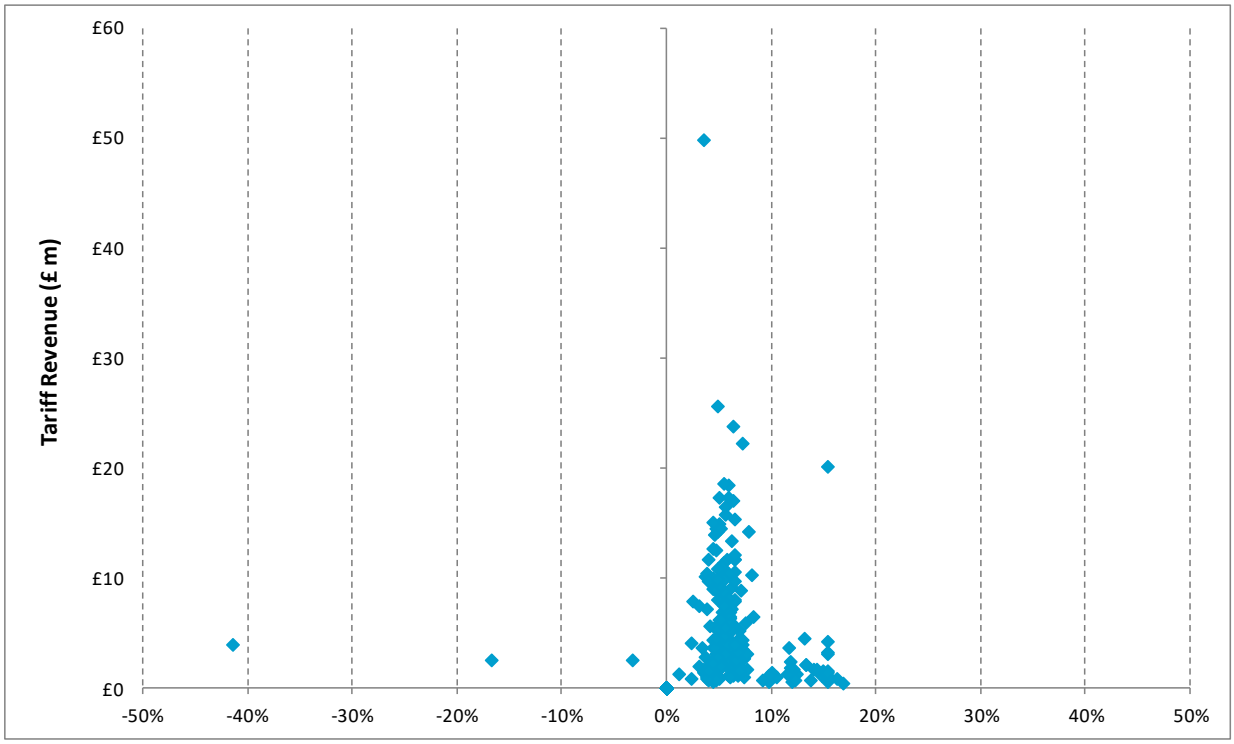
2018/19 estimated tariff revenue) in 2019/20 are likely to range from -41% to +17%.

162. The outlier with a -41% reduction in tariff revenue is a primary healthcare centre that provides outpatient services for cardiology, treatment function code (TFC) 320. The proposed price for this TFC has reduced significantly and it appears this is driven by reduced prices for EY12B - Implantation of Electrocardiography Loop Recorder (with CC Score 0-2) procedure.

163. The second outlier with a -17% reduction in tariff revenue is a hospital with a specific focus on orthopaedics, eye care, spinal and cosmetic surgery. This provider would see a reduction in elective services revenue and an associated reduction in MFF payment related to this activity. This appears to be driven by reduced prices for LB47Z - Major Open Penis Procedures.

164. The reduction in price for these procedures appears to be due to device cost changes and how these feed into national prices.

Figure 11: Change in tariff revenue for independent providers as a percentage of 2018/19 tariff revenue



3.1.5. Anticipated impact of 2019/20 NTPS proposals by category of care

165. This section shows the impact on provider revenue and commissioner expenditure of proposed new prices for different types of care. This analysis is

based on the base run (scenario 1) and not the adjusted model run that controls for changes in the PSF, CQUIN and AfC pay (scenario 2).

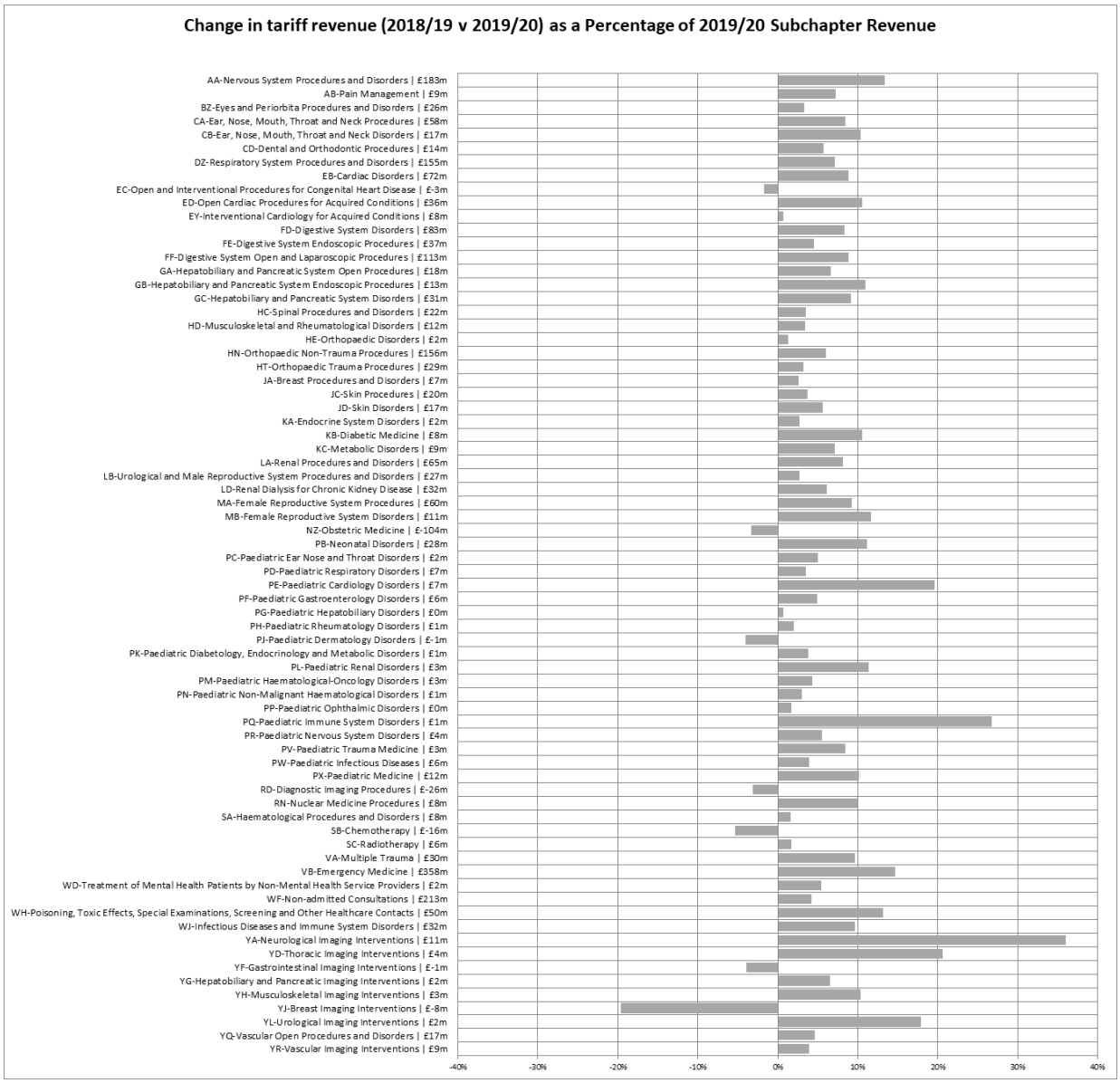
166. We use HRG[28] subchapters to describe the price changes for different categories of care. HRGs are split into chapters, with each chapter relating to care for a particular set of conditions or treatments. These are further divided into subchapters that cover different categories of care.

167. The only exceptions to this rule are the HRG subchapter WF (Non-Admitted Consultations) and subchapter NZ (Maternity). Subchapter WF covers payment for appointments for all types of care when a patient receives care or treatment without a national price and subchapter NZ covers payments for all the three phases of the maternity pathway: antenatal, delivery and postnatal.

168. The proposed changes to national prices would result in gains and losses in tariff revenue of between -19.62% and +36.2 for 72 HRG subchapters. For 30 of the 72 HRG subchapters (42%) changes would fall within ±5%, while for 54 HRGs (75%) changes would fall within ±10%. Figure 12 below shows detailed changes in revenue by HRG subchapter.

[28] HRGs are clinically meaningful groups of diagnoses and treatments that typically occur during a spell of care and use similar levels of resources. The grouping is done using grouper software produced by NHS Digital.

Figure 12: Changes in tariff revenue on different types of care



169. The five HRG categories of care (HRG subchapters) with the largest increase in revenue are shown in the table below:

Figure 13: HRG subchapters with the largest increase in revenue

Chapter	Subchapter	Subchapter name	Difference (%)	Difference (£)

Y	YA	Neurological Imaging Interventions	36.2%	£11 million
P	PQ	Paediatric Immune System Disorders	26.72%	£1 million
Y	YD	Thoracic Imaging Interventions	20.62%	£4 million
P	PE	Paediatric Cardiology Disorders	19.64%	£7 million
Y	YL	Urological Imaging Interventions	17.91%	£2 million

170. The five HRG categories of care (HRG subchapters) with the largest decrease in revenue are shown in the table below. These reductions are due to the following affects:

- Changes in underlying costs as reflected in 2016/17 reference costs
- Changes applied following Expert Working Group feedback

Figure 14: HRG subchapters with the largest decrease in revenue

Chapter	Subchapter	Subchapter name	Difference (%)	Difference (£)
Y	YJ	Breast Imaging Interventions	-19.62%	- £8 million
S	SB	Chemotherapy	-5.38%	-£16 million
P	PJ	Paediatric Dermatology Disorders	-4.02%	-£1 million
Y	YF	Gastrointestinal Imaging Interventions	-3.95%	-£1 million
N	NZ	Obstetric Medicine	-3.33%	-£103 million

4. Impacts relating to equality

171. Under Section 149 of the Equality Act 2010 (Equality Act), NHS Improvement (Monitor) and NHS England have a duty, in exercising their pricing functions, to have due regard to the need to:

- eliminate discrimination, harassment, victimisation and any other conduct prohibited by or under the Equality Act
- advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it
- foster good relations between people who share a relevant protected characteristic and persons who do not share it.

172. Regarding the last two points, we need, in particular, to have due regard to the need to:

- remove or minimise disadvantages suffered by people who share a relevant protected characteristic that are connected to that characteristic
- take steps to meet the needs of people who share a relevant protected characteristic that are different from the needs of people who do not share it
- encourage people who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such people is disproportionately low
- eliminate discrimination.

173. The nine characteristics that are protected under the Equality Act are: age, race (including ethnic or national origins, colour or nationality), sex, pregnancy and maternity, sexual orientation, marriage or civil partnership, gender reassignment, disability, and civil partnership and religion or belief (including lack of religion or belief).

174. We also acknowledge the principle of parity of esteem, by which mental health must be given equal priority to physical health.[29]

4.1. Methodology

175. For the purposes of this impact assessment, we have considered the impact of our proposals on the nine protected characteristics listed above. In particular,

[29] The principle is recognised in NHS legislation and in the NHS Constitution.

we have looked at the extent to which the 2019/20 NTPS proposals are likely to disadvantage individuals with each of these characteristics. In this analysis, we apply the same assumptions set out in section 1 of this impact assessment.

176. Patient age, race and sex are all recorded in 2016/17 HES.[30] This enables us to quantify how proposed changes to national prices and prices for acute emergency care and maternity services in 2019/20 would affect spending on patients in different age, race and sex groups.[31] We also considered the potential impact of the proposals on these groups qualitatively.

177. The other equalities characteristics are not recorded in HES, so for groups with these characteristics we conducted a fully qualitative analysis.

4.2. Age

178. The age of a patient can have a major impact on hospital length of stay and associated healthcare costs. A number of healthcare currencies are split by age to reflect these differences in costs. On average, we estimate the proposed prices would change spending on each age group by +6.8%. These spending changes are driven by the proposed transfer of £1 billion into acute emergency care prices and a higher cost uplift factor, which are intended to ensure that the revenue received for a patient reflects the relative cost of treating that patient. We therefore would not expect any age group to be unfairly disadvantaged by these changes because, on average, prices are increasing across all age groups. Figure 15 below shows the change in spending for different age groups.

Figure 15: Percentage change in tariff payment from 2018/19 by age group

Age group	2018/19 tariff payment (£m)	2019/20 tariff payment (£m)	% change
0-18	3,473	3,704	6.6%
19-65	13,448	14,312	6.4%
Over 65	13,582	14,579	7.3%

[30] The analysis excludes data recorded as other, unknown or unstated.
[31] The data set includes payments for admitted patient care (APC), outpatients (OP) and A&E care settings. It excludes payments for unbundles services, renal and best practice tariffs (BPTs). Maternity payment analysis is conducted outside of the HES dataset and is included within the sex analysis only.

179. Our proposal for non-face-to-face activity (see section 2.3.9 non-mandatory prices) could increase the provision of non-face-to-face services and this could have differential impacts on some patient groups eg age and disability. To mitigate this potential impact, providers and commissioners should ensure they take into account the needs of different patient groups when designing services.

180. We would not expect any other aspects of the proposals to have material disproportionate impact on any age group. Therefore, overall, we would not expect the proposals to have a material disproportionate impact on any age group.

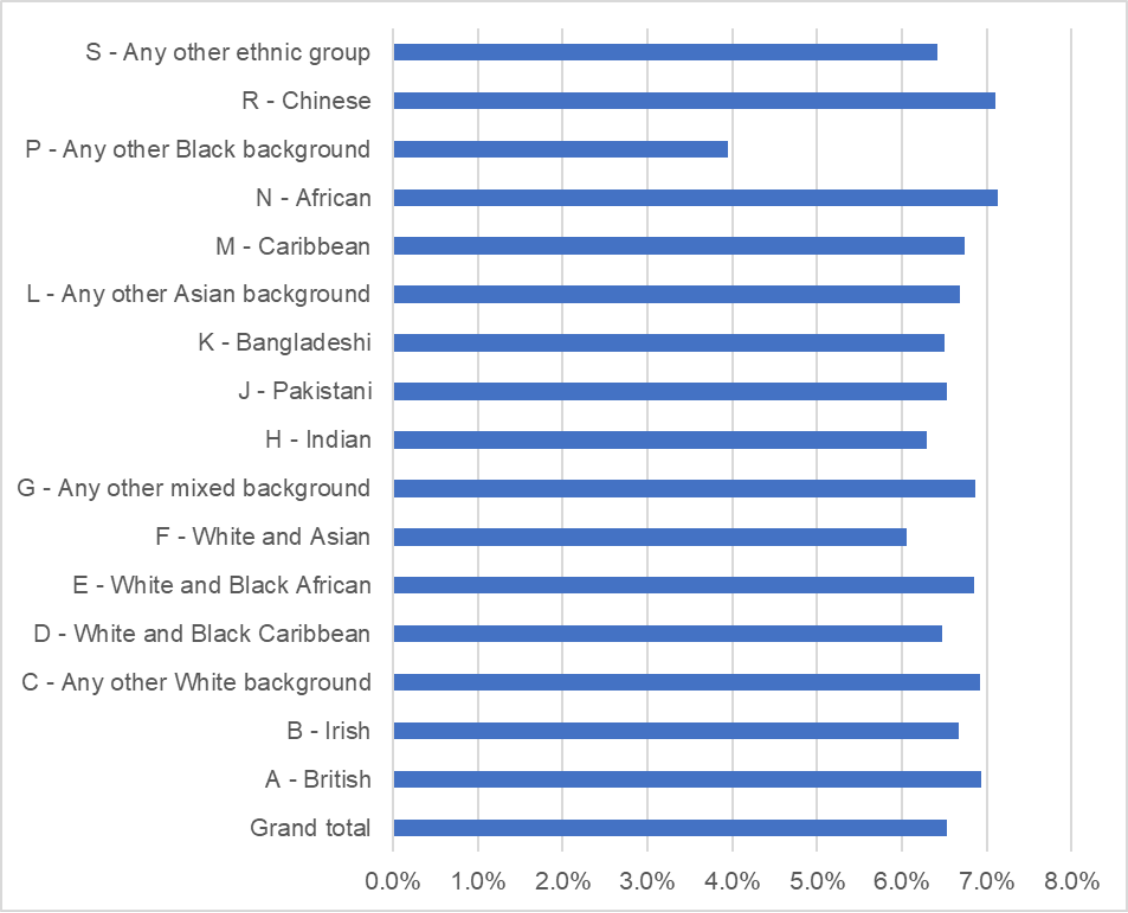
4.3. Race (including ethnic or national origin, colour or nationality)

181. The NTPS does not distinguish between patients based on their race, ethnicity or nationality. However, there are health conditions that are disproportionately experienced by people from certain ethnic groups[32] and so the NTPS could have a disproportionate impact on different ethnic groups. We do not expect any of the 2019/20 proposals to have a disproportionate impact on different ethnic groups.

182. We estimate the proposed prices would change spending on each ethnic group by between +4% and +7.1%. On average change is spending is estimated to be +6.5% across all ethnic groups. Figure 16 shows the percentage change in tariff spending for each ethnic group.

[32] Health conditions such as diabetes, hypertension, sickle cell and thalassaemia disproportionately affect people from Black and Ethnic Minority (BME) groups.

Figure 16: Percentage change in tariff spending by ethnicity from 2018/19 to 2019/20



183. We would not expect any other aspects of the proposals to have material disproportionate impact on any age group. Therefore, overall, we would not expect the proposals to have a material disproportionate impact on any age group.

4.4. Sex

184. Certain procedures are, by their nature, specific to male and female patients and there are HRG chapters with sex-specific procedures, ie male or female procedures. We do not expect any of the 2019/20 NTPS proposal to have a material disproportionate impact on men or women.

185. We estimate that the proposed prices would increase spending for both male and female patients. These spending changes are driven by the proposal to transfer £1 billion into acute emergency care prices and a higher cost uplift factor, which are intended to ensure that the revenue received for a patient reflects the relative cost of treating that patient. We therefore would not expect

patient sex to be unfairly disadvantaged by these changes because, on average, prices are increasing across all age groups. Figure 17 illustrates this as both male and female patients will likely see similar increases in tariff spending.

Figure 17: Percentage change in tariff spending by ethnicity from 2018/19 to 2019/20

Sex	2018/19 tariff payment (£m)	2019/20 tariff payment (£m)	% change
Male	14,738	15,741	6.8%
Female (inc maternity)	15,995	17,093	6.9%

4.5. Pregnancy and maternity

186. The 2019/20 NTPS proposals would reduce spending on maternity by 3.33% (£103 million) compared to the 2018/19 NTPS. This is largely due to the proposed reduction in CNST payments to recover an over-reimbursement of CNST costs in 2018/19. We do not expect this reduction in maternity expenditure to have a material impact on service provision because provider control totals were adjusted in-year for 2018/19, and we would take this projected impact into consideration when setting control totals for 2019/20.

187. Our analysis of impacts without the effects of CNST suggest provider revenue and commissioner spend would increase by £28 million. The impact of CNST is therefore £132 million. This reduction in provider revenue and commissioner spend reflect changes in CNST related costs on a year-on-year basis. To ensure this does not impact on patients and quality an in-year adjustment through control totals will likely be made.

4.6. Sexual orientation

188. The national tariff does not distinguish between patients on the basis on their sexual orientation. We do not, therefore, expect the 2019/20 NTPS proposals to have disproportionate impacts on population groups with a particular sexual orientation.

4.7. Marriage and civil partnership

189. The national tariff does not distinguish between patients based on their marital or civil partnership status. We do not, therefore, expect the 2019/10 NTPS

proposals to have disproportionate impacts on population groups with a marriage or civil partnership status.

4.8. Gender reassignment

190. The national tariff does not distinguish between patients based on their gender. However, our pricing policies for gender identity services could impact on healthcare access for individuals with gender incongruence. The 2019/20 NTPS proposals are unlikely to affect the delivery of gender identity services and, as such, we do not anticipate they would have a disproportionate impact on individuals with a gender reassignment status.

4.9. Disability

191. The updated HRG4+ phase 3 currency design enables us to distinguish more accurately between care provided for patients with different levels of complexity. This helps to ensure providers are more appropriately reimbursed for providing care to patients with disabilities. We are also proposing national currencies and non-mandatory prices to support the commissioning of wheelchair services. We do not, therefore, expect 2019/20 NTPS proposals to have disproportionate impacts on population groups with disabilities.

4.10. Religion or belief (including lack of belief)

192. The national tariff does not distinguish between patients based on their religion or belief. We do not, therefore, expect the 2019/20 NTPS proposals to have disproportionate impacts on people from different religious backgrounds or with different religious beliefs.

4.11. Other considerations

193. While some of the 2019/20 NTPS proposals might potentially have a negative impact on certain patients with protected characteristics, the rules on locally determined prices give commissioners and providers the flexibility to agree local payment approaches or prices to mitigate any unintended consequences of our proposals. We also expect providers and commissioners to take the necessary steps to ensure they comply with the equality duty when designing and/or commissioning services. Further to this, consultees are invited to provide any comments or information which may assist with any further qualitative or quantitative assessment of impacts in relation to equality.

5. Patient Choice

194. We have assessed the impact of the 2019/20 NTPS proposals on patient choice and competition.

5.1. Overview

195. The NHS Long Term Plan sets out proposals to increase collaboration between commissioners and providers, supported by the development of ICSs, to use their collective resources more effectively in support of better quality of care and population health for the communities they serve. This impact assessment should be considered in that context.

196. Most of the proposals in the NTPS are designed to make national prices more reflective of providers' efficient costs. All other things being equal, we would expect this to increase incentives for providers to improve the efficiency of services and to support the effective operation of patient choice for elective care and other relevant services. We do not, therefore, expect these proposals to have a significant impact on patient choice and competition.

5.2. Methodology

197. Section 69 of the Health and Social Care Act 2012 requires NHS Improvement to assess the likely impacts of pricing proposals but does not specify the form of the assessment.

198. In our impact assessment we bear in mind the competition checklist criteria set out in the Competition and Markets Authority (CMA)[33] guidelines on competition impact assessments.[34]

5.3. Assessment

5.3.1. One-year tariff

199. We propose a one-year national tariff to enable us to respond flexibly to changing circumstances in the NHS, address any unintended consequences resulting from the proposed 2019/20 policy changes, and ensure the payment

[33] In the NHS Long Term Plan it is proposed to reduce the role of the CMA in relation to NHS pricing.
[34] See CMA Competition Impact Assessment (CMA50), Part 1 (overview) and Part 2 (guidelines), 15 September 2015: www.gov.uk/government/publications/competition-impact-assessmentguidelines-for-policymakers

system remains relevant and supports the delivery of the Long Term Plan[35]. The proposed one-year tariff changes would apply across all providers and commissioners and, as such, their impact is likely to be minimal.

5.3.2. National prices and prices for emergency care and maternity services

200. In setting the proposed national prices and prices for acute emergency care and maternity services, we make four adjustments that affect the level of all prices (ie inflation, CNST, efficiency and 'cost base' adjustment) to ensure that, before applying the other adjustments, total spending in each year of the national tariff is the same as in the previous year.

201. These adjustments impact on the relationship between prices and costs in the final tariff. Their impact therefore depends on whether the final tariff results in a price that is higher or lower than providers' efficient costs. The overall price level adjustments are applied evenly across all providers and, in the light of other aspects of the healthcare sector. eg other aspects of the regulatory regime, we expect their impact would be limited.

5.3.3. Blended payments for emergency care

202. The proposed blended payment approach for emergency care is unlikely to have a material impact on patient choice and competition as they are not key drivers of quality in the provision of emergency care.[36] This is because patient choice is limited and there is no financial incentive to attract patients requiring emergency care.

5.3.4. New MFF values

203. The proposed updates to MFF values are unlikely to have a material impact on patient choice and competition. The proposed change reflects the underlying costs of providing services by different providers more accurately. This should mean that providers with (structurally) higher costs get paid more for providing their services, which should give them stronger incentives to make their

---

[35] NHS objectives are set out in the NHS Long Term Plan available at: https://www.longtermplan.nhs.uk/

[36] CMA's decision on Burton and Derby merger shows that hospitals do not compete on non-elective services: https://assets.publishing.service.gov.uk/media/5ac5df37ed915d76a313cb06/derby_burton_decision.pdf

.

services more attractive to patients or to continue providing them if they were loss making under the current tariff.

5.3.5. Specialist top-ups

204. Specialised services tend to be highly concentrated in a limited number of specialist centres, as they require a critical mass to achieve the best clinical outcomes and to maintain financial viability.

205. Specialist top-ups make up around 1% of nationally priced spending, and most providers receive little or no specialist top-up revenue so would not be substantially affected by the changes. For the services still affected by changes to specialist top-ups we introduced in 2017/18 and 2018/19 NTPS,[37] we would be implementing another 25% transition in 2019/20 following the same principles used in the 2017/19 NTPS. Phasing in the changes to top-ups helps to mitigate the financial impact on providers and the risk of providers withdrawing services.

206. Overall, we do not expect our proposals[38] to have an adverse impact. as other factors are likely to limit how much healthcare activity would change in response to a change in price.

5.3.6. Best practice tariffs

207. In general, we expect these BPTs to financially incentivise healthcare providers to deliver higher-quality services which lead to better patient outcomes and therefore have a positive impact on competition. However, there may be providers that, for reasons outside their control, are less able to achieve the criteria for a BPT. These providers may choose not to adopt the service specification required to receive the BPT price would still be paid for the care, albeit at a lower price. We do not expect the proposal to have an adverse impact as other factors are likely to limit how much healthcare activity would change in response to a change in price.

---

[37] Orthopaedics, paediatrics and spinal cord injury services lost funding as a result of changing the method for calculating top-up payments from top-ups based on the SSNDS to the PSS designation of specialist services in 2017/19.

[38] Proposal to update the current PSS identification rule (IR), provider eligibility lists, Provider Eligibility Lists the eligibility criteria for haemoglobinopathies.

5.3.7. Changes in NHS procurement arrangements

208. We do not expect there to be any material impact on patient choice or competition between providers resulting from changes in NHS procurement arrangements. The proposed adjustments to prices, to reflect the central funding of SCCL, would apply across all providers and commissioners. A potential issue could be that providers are disincentivised from looking for more efficient supply chain alternatives because they are tied into SCCL through the tariff price adjustment. However, the national tariff rules do not prohibit providers to move to competitors is it is more efficient to do so.

5.3.8. Maternity Services

209. The proposed changes to maternity payments are intended to support patient choice and encourage providers to improve the quality of care women receive. While the proposals to unbundle specialist fetal medicine and AIP from the MPP could limit the choice of provider to specialist centres, we believe that restricting the provision of specialist care to specialist/designated providers would improve clinical care and outcomes for patients.

210. The proposal to set a separate price for home births would also help improve access by ensuring sustainable provision of maternity care by smaller providers. The move to non-mandatory prices could in theory result in providers and commissioners deciding not to use the maternity pathway prices and agreeing local prices. This could act as a barrier to market entry particularly for smaller providers and limit patient choice for women. To mitigate this risk, providers and commissioners would be strongly encouraged to use the non-mandatory prices and the non-mandatory pathway prices would be the default payment approach for non-contracted maternity activity.

5.3.9. Non-mandatory prices

211. We do not expect other proposed non-mandatory prices to have a material impact because providers and commissioners will still be able to agree local prices if they feel the prices are either too high or too low.

6. Conclusion and next steps

212. Our analysis shows that once adjustments to the financial architecture (ie adjusting for PSF, CQUIN and AfC) are made, we anticipate the proposals set out in the consultation document would have a positive impact on 137 NHS providers (74%) and a reduction in revenue for 47 NHS providers (26%) would when compared with 2018/19 prices. Our analysis indicates the proposals to transfer £1 billion of PSF funding to non-elective and A&E prices in the tariff and the inclusion of AfC pay data for 2018/19 and 2019/20 are the main drivers of this.

213. We estimate that for 164 NHS providers (89% of the providers in our analysis), the change in tariff revenue as a proportion of operating revenue, relative to our projections for 2018/19, is likely to be within ±1 % for 2019/20. For 181 NHS providers (98% of the providers in our analysis), the change in tariff revenue is likely to be within ± 2% for 2019/20. For the remaining three NHS providers, this change is likely be within ± 2.5%.

214. Over the course of the 2019/20 tariff, we will look to assess the actual impacts of the policies that have been the subject of this impact assessment, to inform future pricing policy development.

Annex 1: NHS Improvement's statutory duties

215. In this annex all references to NHS Improvement are references to Monitor unless otherwise stated.

216. Under Section 69(5) of the 2012 Act, NHS Improvement's impact assessment must include an explanation of how the discharge of NHS Improvement's duties under Sections 62 and 66 would be secured by implementation of NHS England and NHS Improvement's proposals.[39][66] This annex sets out each of the duties with an explanation of:

- how the implementation of the proposals would secure the discharge of that duty
- where appropriate, how NHS Improvement has complied with the duty in developing and making these proposals.

217. Where appropriate, we cross-reference to the consultation notice or this impact assessment itself.

218. NHS Improvement's general statutory duties are set out in Sections 62 and 66 of the 2012 Act; and further statutory duties related to pricing are set out in Sections 116(13) and 119(1) to (4) of the 2012 Act. The following subsections address each provision in turn.

6.1. Section 62 of the 2012 Act

6.1.1. Section 62(1): Protect and promote the interests of patients[40]

219. Consideration of the interests of patients is fundamental to the proposals in the consultation notice. This duty requires NHS Improvement to protect and promote the interests of patients by promoting the provision of healthcare services which:

---

[39] The 2012 Act also provides that Monitor should state why the duties would not be secured by the exercise of Monitor's statutory functions under the Competition Act 1998 and Part 4 of the Enterprise Act 2002. The exercise of those functions would not enable NHS Improvement to develop a comprehensive payment system, in particular a system that would, for example (i) involve setting national prices for specific services in a way that promotes effective and economic provision of those services or (ii) a framework for national or local pricing that takes proper account of the duties of commissioners, which are, in particular, to ensure fair access to services using a limited budget and to make best use of resources in doing so.

[40] In this annex, the term 'patients' is used as shorthand for the group described in the 2012 Act – "people who use healthcare services".

- are economic, efficient and effective and
- maintain or improve the quality of the services.

220. The way in which our proposals would discharge this duty is explained in detail below, by reference to each limb of the duty.

6.1.2. Section 62(1)(a): Economic, efficient and effective provision of healthcare services

221. NHS Improvement and NHS England's method for setting national prices follows two main principles:[41]

- prices should reflect efficient costs
- prices should provide appropriate signals to providers and commissioners. Following these principles creates a strong incentive for providers to reduce their costs and to promote efficient and effective service provision.

222. We consider that the proposals NHS Improvement and NHS England have developed following those principles would promote secure economic, efficient and effective provision of healthcare services. In particular, we would highlight the proposals on MFF, maternity services and the move to a blended payment approach for emergency care:

- Moving to a blended payment approach for emergency care will support a more effective approach to resource and capacity planning that focusses on making the most effective and efficient use of resources.
- Transferring £1 billion from PSF into prices for acute emergency care
- Current MFF values do not accurately account for the differences in unavoidable costs between providers as the data used to calculate the MFF has not been updated since 2010. The new MFF values will begin to bridge the gap.
- Changes to our method which result in the CUF increasing to 3.8% will ensure prices better reflect cost-pressures facing providers in the future.

6.1.3. Section 62(1)(b): Maintaining or improving quality of healthcare services

223. To help maintain and improve the quality of healthcare services, NHS Improvement and NHS England's proposals seek to ensure that providers are

[41] NHS Improvement and NHS England's method for setting national prices is discussed in Section 11 of Part A and Section 4 of Part B of the consultation notice

appropriately reimbursed for the services they provide. This is supported by provisions such as the market forces factor (MFF). The MFF helps to ensure that provider revenue reflects the unavoidable financial pressures they face due to geographical cost differences. When providers are appropriately reimbursed, the quality of care they provide should be maintained. In addition, the proposed specialist service top-ups ensure correct payment for these services, allowing providers to continue to offer critical service lines and to deliver complex care.[42]

224. To help maintain or improve the quality of mental health services NHS Improvement and NHS England propose to require commissioners and providers to adopt a blended payment approach which incorporated a fixed element and a variable amount linked to quality and outcomes. This is to help ensure providers are more appropriately reimbursed for the services they provide, support the delivery of integrated care and policy objectives of Integrate Care Systems (ICS). This payment approach is likely to improve the quality of activity and cost data and lead to improves outcomes for patients. Where prices are to be set locally, principles which must be applied include a requirement to act in the best interests of patients. Quality must be considered as part of this requirement.[43]

225. NHS Improvement recognises that one of the potential effects of the pricing method is that it may produce prices which provide an incentive to reduce quality. For every service, some providers will currently have costs which are below the national price, and will therefore make a loss if they do not take action to reduce their costs. Costs can be reduced by improving efficiency, but they could also be reduced by reducing patient access and quality. However, this risk is mitigated by other regulatory mechanisms designed to ensure care quality and appropriate access, such as Care Quality Commission inspections and our Single Oversight Framework.

6.1.4. Section 62(2): Have regard to likely future demand for healthcare services

226. While pricing below some providers' costs could incentivise those providers to provide services more efficiently, there are risks to patients' long-term interests from prices being set too low. Providers not being adequately compensated for

[42] National variations such as the MFF and specialist top-ups are discussed in Section 12 of Part A and Section 5 of Part B of the consultation notice.

[43] These proposals for mental health payment are discussed in Section 13.1 of Part A and Section 6.5 of Part B of the consultation notice.

the services they provide could lead to them withdrawing provision of these services and/or under-investing in their future delivery.

227. NHS Improvement has had regard to the future demand for healthcare services in the development of the consultation notice proposals. For example, through the use of the HRG4+ currency design for setting prices, the transfer of £1 billion from PSF into prices, proposed update to MFF and proposed specialised services top-up policy, we have sought to ensure prices are cost-reflective to help maintain the financial sustainability of services. Similarly, updating the high cost drugs and devices list can help to ensure appropriate reimbursement for these items. This supports the provision of care for patients who will benefit from access to these drugs or devices.

228. Our proposal to introduce a blended payment approach for emergency care is designed to encourage commissioners and providers to work more collaboratively and agree ways to use the available resources to manage healthcare demand and provide high-quality, responsive services for patients in the more cost-efficient way.

229. A blended payment approach could provide shared incentives for commissioners and providers to reduce avoidable A&E attendances and non-elective admissions by providing the right care in the right place at the right time – and shared financial responsibility for levels of hospital activity.

6.1.5. Section 62(3): Competition and co-operation

230. NHS Improvement has had regard to competition and co-operation in the development of our proposals. The proposed changes to the national tariff payment system that we consider may have implications for choice and competition are assessed in Section 5 of this report. They include:

- one-year tariff
- national prices and prices for emergency care and maternity prices
- blended payment approach for emergency care
- new MFF values
- specialist top-ups
- best practice tariffs
- changes in NHS Procurement arrangements
- maternity services
- non-mandatory prices.

6.1.6. Section 62(4), (5) and (6): Integration and co-operation

231. The local variation rules are intended to give commissioners and providers an opportunity to innovate in the design and provision of services for patients. This might include, for example, designing a new integrated service that combines service elements, or supporting integration of primary, secondary and social care with payment aligned to outcomes.

232. The proposal to introduce a blended payment approaches for emergency care and maternity services are designed to incentivise commissioners and providers to work more collaboratively and agree ways to use the available resources to manage healthcare demand.

6.1.7. Section 62(7): Patient and public involvement

233. NHS Improvement and NHS England undertook a range of consultation and engagement activities as part of developing the proposals for the 2019/20 NTPS. For example, they gave patients and other members of the public an opportunity to review and comment on our national tariff proposals by publishing the engagement document *2019/20 Payment reform proposals*.[44] Patient representative and condition representative groups were invited to comment as part of the stakeholder engagement process. Their feedback was taken into account as part of NHS Improvement and NHS England's decision-making on the national tariff. Any member of the public can comment on our proposals, but we recognise that the technical nature of the NHS payment system may not be of great interest to patients and the wider public.

234. Further information on our engagement activities can be found in Section 4 of Part A of the consultation notice.

6.1.8. Section 62(8): Clinical and public health advice

235. To discharge this duty, NHS Improvement is required to obtain appropriate advice from persons who have a broad range of professional expertise in (a) the prevention, diagnosis or treatment of illness and (b) the protection or improvement of public health.

236. NHS Improvement and NHS England engaged extensively with clinical experts during the development of proposals for the 2019/20 NTPS; for example, we

[44] https://improvement.nhs.uk/resources/201920-payment-reform-proposals/

used the clinical expertise of the National Casemix Office's Expert Working Groups (EWGs). The EWGs are responsible for advising on the design of the casemix classifications known as healthcare resource groups (HRGs). They consist of clinicians nominated by their professional bodies and Royal Colleges. We held discussions on currency design and development and then separate meetings on price relativities. In some areas further follow-up discussions occurred with the relevant EWG and other experts. In addition, the engagement document presented an opportunity for the wider clinical community to review and comment on our proposals.

237. This year as part of our Enhanced Impact Assessment (EIA) project, we initiated pre- impact assessment discussions on price relativities with providers (called the provider price check). This took place at the same time as the engagement with the EWGs and allowed us to obtain feedback on price relativities that are not correct. It also helped us to understand the differences between NHS Improvement's impact assessment and those of individual providers, and to identify how we could resolve these differences to make future impact assessments more robust.

238. Nominations for the inclusion of drugs and devices in the high cost drugs and devices list can be submitted by anyone for consideration by a drugs and devices steering group, which include clinical representatives in the form of pharmacists.

239. Our engagement is discussed further in Section 4 of Part A of the consultation notice.

6.1.9. Section 62(9): To promote a comprehensive health service

240. The proposals in the consultation notice are consistent with the discharge by the Secretary of State of his duty to continue the promotion of a comprehensive health service. In particular the proposals:

- Cover a wide range of NHS services, providers and settings, including acute and community services, and both nationally and locally determined prices. The only exceptions are areas where the legislation specifically provides an exception (eg public health services) or an existing payment mechanism (eg primary care services).
- Cover mental health services as well as physical health services.

- Apply to services for all types of patients, including variations to reflect the differing costs of dealing with more complex patients, for example the national variation to top-up payments for specialised services.
- Are specifically designed to support a comprehensive and efficient NHS which provides quality services to patients.

241. NHS Improvement and NHS England work together closely in setting our tariff proposals – the policies align with NHS England's annual mandate. All the proposals in the consultation notice have been jointly decided by NHS Improvement and NHS England; the latter is subject to the duty in Section 1(1) of the NHS Act 2006 concurrently with the Secretary of State.

242. The provision of a comprehensive health service is promoted by our proposals which enable the appropriate reimbursement of providers and delivery of service models that meet best practice criteria.

6.1.10. Section 62(10): Non-discrimination between providers

243. NHS Improvement has had regard to its duty under Section 62(10) when setting prices. We have not set different prices for public and private providers. We expect the proposals to treat providers differently on the basis of the services they provide or the nature of the patients they treat, not on the basis of their status, and the proposals are not designed to promote the provision of services by a particular type of organisation. Similarly, the purposes of the proposed changes such as the high cost drugs and devices list, maternity pathway payment system, HRG4+ currency, new mandatory prices or new non-mandatory prices, blended payment approach, are to achieve particular outcomes (such as incentivising best clinical practice or ensuring that prices more accurately reflect efficient costs) rather than to favour particular types of providers of NHS services.

6.2. Section 66 of the 2012 Act

244. Section 66 requires that NHS Improvement must have regard to various matters listed in that section when exercising its functions. The first matter listed is safety, and Section 66 makes it clear that when having regard to the other matters listed below, NHS Improvement should do so only so far as is consistent with maintaining the safety of patients.

6.2.1. Section 66(1): Safety of people who use healthcare services

245. NHS England and NHS Improvement have applied the approach that prices should reflect the costs that a reasonably efficient provider should expect to incur in supplying healthcare services to the level of quality expected by commissioners. NHS England and NHS Improvement have also had regard to the risks of prices being set too low, including the potential risks to safety.[45] The considerations set out in relation to Section 62(1)(b) of the 2012 Act (quality – see Section 1.1.3 above) are also relevant.

246. In relation to locally determined prices, the requirement for commissioners and providers to apply the principle that local payment approaches must be in the best interests of patients is being retained. In applying this principle, they should consider how a local payment approach would maintain or improve safety. In addition, adjustments to payments through the MFF and any local modifications can help to ensure that healthcare services can be delivered safely where they are required by commissioners for patients, even if the reasonably efficient cost of providing these services is higher than the national price.

6.2.2. Section 66(2)(a): Continuous improvement in quality

247. NHS England and NHS Improvement have had regard to the risk to continuous improvement in quality when setting prices. Our proposals support continuous improvements in the quality of care and services. One example is the proposals for BPTs, which are explicitly designed to encourage best practice and to incentivise improvements in quality.[46][77] The considerations set out in relation to Section 62(1)(b) of the 2012 Act (see Section 1.1.1 above) are also relevant.

6.2.3. Section 66(2)(b), (c) and (d): Duties of commissioners – ensuring fair access and best use of resources

248. NHS Improvement and NHS England have had regard to the needs of commissioners to ensure fair access to services and best use of resources.

249. We explain in Section 1.1.2 of this annex how the proposals contribute to economic, efficient and effective care; for example, through the use of the HRG4+ currency, transferring £1 billion of PSF into national prices and prices

[45] See Section 11.6 of Part A of the consultation notice.
[46] Proposals for BPTs are discussed in Sections 10.7 of Part A, 7.4 of Part A, 5.3.1 of Part B and 4.2.2 of Part B of the consultation notice.

for acute emergency care and proposals for specialised services top-ups. These proposals facilitate the design of prices which reflect the cost of treating the patient. Cost-reflective prices strengthen provider incentives to deliver care economically and efficiently. This in turn supports the best use of resources helping to ensure that patients have equal opportunities to access NHS care. They also help commissioners commission the most effective mix of services for their population within the available budget.

250. The MFF helps to ensure that provider revenue reflects the unavoidable financial pressures they face due to geographical cost differences and so prevents these from affecting patients' access to care. Our proposal to update the MFF values will further ensure patients' access to care is not affected.

251. The transparency of national prices enables commissioners to better plan for service delivery, with more certainty around spending. Similarly, mental health proposals to adopt a blended payment approach support local providers and commissioners in taking an informed view about the effective use of resources.

252. The duties on commissioners and the limits on the availability of NHS resources are also a factor considered in the method for determining national prices – in particular when setting the cost base and efficiency factors.

6.2.4. Section 66(2)(e): Desirability of co-operation to improve quality of services

253. Our proposals have regard to the desirability of co-operation to improve the quality of services.

254. We have retained the rules for locally determined prices, which allow for local variations which, for example, promote service integration (eg pathway payments). Under rule 1, providers and commissioners must follow a set of principles when agreeing a local payment approach. These principles include the requirement for constructive engagement between provider and commissioner.

255. HRG4+ is intended to better reflect the complexity and other aspects of treatment and care. This will facilitate the appropriate reimbursement of providers, as payments will better reflect the costs incurred when treating patients of differing levels of complexity.

256. Setting prices that more appropriately reimburse providers for the services they provide supports investment in measures to improve the quality and efficiency of services; for example, collaboration to develop payment models that bring together a number of care elements across a patient pathway. Our proposal to transfer £1 billion of PSF into prices demonstrate our intent on ensuring prices more appropriately reimburse efficient costs.

257. Our proposals for mental health services, in particular for linking payment to the achievement of outcomes, may facilitate local discussions about the needs of patients and how the payment system can support safe, effective and evidence-based care that is, at a minimum, NICE concordant. The use of local quality and outcome measures for both payment and monitoring purposes can support the effective use of resources in the NHS and help identify opportunities for investment in mental health.

6.2.5. Section 66(2)(f) and (g): Research and training

258. The proposals in the consultation notice do not include any specific changes to actively promote research, education and training, which are funded through other mechanisms. National prices do not include training costs and therefore do not reimburse providers for them. Provider training costs are funded separately.

6.2.6. Section 66(2)(h): Secretary of State's guidance to Monitor on a document under Section 13E of the NHS Act 2006 (quality outcomes framework)

259. The Secretary of State has not published any guidance under this provision.

6.3. Section 116(13) of the 2012 Act

260. Section 116(3) requires that when exercising its pricing functions NHS Improvement must have regard to the objectives and requirements in the government's mandate to NHS England.

261. NHS Improvement has had regard to the mandate as the proposals were formulated; a number of our proposals support mandate objectives.

262. For example, Objective 2 of the mandate is "To help create the safest, highest quality health and care service", and we outline in Section 1.1.3 of this annex how the proposals help to maintain or improve the quality of healthcare services.

263. Objective 3 is “To balance the NHS budget and improve efficiency and productivity”, and we outline in Section 1.1.2 of this annex how the proposals contribute to the economic, efficient and effective provision of healthcare services.

264. We also note that NHS England, which is subject to the mandate, has agreed these proposals.

6.4. Section 119 of the 2012 Act

265. Section 119 of the 2012 Act imposes two groups of statutory duties.

6.4.1. Section 119(1): Fair level of pay for providers of healthcare services and having regard to differences between providers

266. NHS Improvement and NHS England must have regard to the different costs incurred by providers that treat different types of patients and differences in the range of healthcare services offered by providers. The effect of this duty is to require NHS Improvement and NHS England to make provisions for adjustments in prices, taking into account variations in clinical complexity.

267. The HRG4+ currency would enable the use of more recent cost data when setting prices, and is designed to better reflect the costs associated with the provision of care of varying levels of complexity. Its adoption would support fairer reimbursement for providers.

268. The specialised services top-up policy enables up-to-date cost-reflective payments for specialist care which are not accounted for under the HRG4+ currency. The policy has been explicitly developed to enable provision of specialist and complex care to be fairly reimbursed. We developed it with consideration of the analysis by the University of York on the degree of payment difference caused by specialisation at each provider.

269. In addition, the MFF deals with regional cost variations. This rule is designed to compensate providers for the cost differences of providing healthcare in different parts of the country. This helps to ensure that providers receive a fair level of reimbursement. The proposed new MFF values will ensure that regional cost variations are more appropriately reimbursed.

270. In addition, the framework for locally determined prices has been designed to promote economic, efficient and effective provision of healthcare services, even

in circumstances where national currencies and prices may not adequately reflect relevant differences between providers. One of the principles applying to all locally determined prices is a requirement to act in the best interests of patients. Cost- effectiveness must be considered as part of this requirement.

271. The local variation rules allow nationally specified currencies or prices to be amended to reflect significant differences in casemix compared with the national average. In addition, the method for assessing applications for local modifications allows additional funds to be made available to providers of essential services that would otherwise be uneconomical. Local modifications help to ensure that healthcare services can be delivered safely where they are required by commissioners for patients, even if the reasonably efficient cost of providing these services is higher than the national price.

6.4.2. Section 119(2), (3) and (4): Standardisation of currencies

272. A system of national currencies is one of the building blocks of the payment system for NHS care. For 2017/19, NHS England and NHS Improvement propose using the HRG4+ currency as it better reflects the costs associated with the provision of care of varying levels of complexity. Its adoption should help to reduce the time spent negotiating local variations to national prices.

Appendix 2: Report of the 2019/20 Enhanced Impact Assessment process

Introduction

273. Understanding the impact of national tariff proposals is very important to the joint NHS Improvement and England pricing teams. It allows the effects of price and policy changes to be modelled before they are proposed to the sector. To ensure our impact assessments are as accurate as possible, we run the Enhanced Impact Assessment (EIA) project in the build up to the statutory consultation on national tariff proposals.

274. The EIA project works by sharing impact assessment material with selected participants and comparing the results of their assessments with ours. The outcomes of the project are fed back into improving the impact assessments we produce. This appendix outlines the processes followed and discusses the results that were discovered.

275. We would like to thank the participants for their time and effort, and NHS Providers and NHS Clinical Commissioners for help identifying participants.

Process

276. We followed the following process:

Recruitment of participants

277. NHS Providers and NHS Clinical Commissioners publicised the EIA exercise and asked for organisations to volunteer. We selected participants to ensure there was a spread of providers both in terms of size, speciality and geographical spread. A private provider was also included. As in previous EIAs it was more difficult to encourage CCGs to come forward and only one CCG (East Cheshire CCG) volunteered. This CCG was subsequently unable to take part in the EIA process and therefore the 2019/20 EIA exercise only involved providers.

Participating Providers
The Walton Centre NHS Foundation Trust
The Robert Jones and Agnes Hunt Orthopaedic Hospital Foundation Trust

Participating Providers
Birmingham Women's and Children's NHS Foundation Trust
Dorset County Hospital NHS Foundation Trust
University College London NHS Foundation Trust
University Hospitals of North Midlands NHS Trust *(subsequently unable to take part)*
York Teaching Hospital NHS Foundation Trust
Mid Cheshire Hospitals Foundation Trust
Ramsey

Communications with participants

278. We set up a joint call to outline the project and it's aims. This call also set out the expectations of participants to ensure they were all willing and able to continue.

Production of impact assessments

279. We shared impact analysis at both aggregate and detailed levels with participants. Initial calls were held to ensure those taking part understood the template and what the next steps were. Participants then produced their own versions of the impact assessment using the detailed instructions set out in the template. Participants were encouraged to provide their detailed calculations to support the investigation of any discrepancies that were apparent.

Comparison of impact assessments

280. An initial comparison of the impact assessments was undertaken to identify the areas with the largest discrepancies in terms of activity counts and/or income. The joint Pricing team and participants then analysed these differences to try and identify causes. Face to face meetings were held to discuss the results and understand what was causing differences. Further work and discussions took place to follow-up on the differences identified.

Process improvements

281. The 2019/20 EIA process was revised following feedback from participants in the EIA process for the 2017/19 NTPS. We made the following improvements:

- The impact assessment methodology was made clearer, with detailed descriptions of which activity data to use and more clarity about what should be included or excluded from the analysis.
- A change to only producing an impact assessment for the proposed 2019/20 tariff rather than looking at the change in income compared to the previous tariff. This meant that more HRGs and activity could be included. For example, it was not necessary to exclude HRGs impacted by changes in the high cost drugs and devices list.
- Inclusion of specialised services top-ups.
- Holding the 2019/20 earlier in the year. This meant that participants had longer to produce their assessments and investigate discrepancies. It also meant that that we were not seeking feedback from providers over the summer. One drawback of this approach was that the draft prices used for the EIA process did not include any manual adjustments to draft price relativities as a result of Expert Working Group (EWG) feedback.
- Increased focus on investigating differences in activity, as well as revenue, to fully understand causes of discrepancies.
- Inclusion of more detailed data to enable participants to conduct more thorough analysis.

282. These improvements have meant that the EIA process this year has been more comprehensive and has supported a focus of effort on identifying and understanding discrepancies between the impact assessments.

Issues observed

283. In the course of the discussions and analysis the following issues were uncovered:

Data issues

- Critical care bed days. As part of the EIA process it was identified that critical care bed days had not been removed from the HES activity data in the pricing calculation model. This had an impact on excess bed day counts, trim points and activity counts in some HRGs.

- Issues with the MFF values.
  - The MFF value used in the initial impact assessment for Birmingham Women's and Children's NHS Foundation Trust was not the updated value for the merged trust.
  - Calculation of MFF for independent providers was not accurate.
  - The decimal places used for MFF values was not consistent.
- Presentation of prices in the template. Prices in the template were displayed to the nearest penny, but the prices used in the calculations were to many more decimal places.
- It was not always possible to identify all activity that is subject to local pricing arrangements (and which should therefore be excluded from the impact assessments). The data submitted by providers does not always fully reflect activity that is subject to local pricing and payment arrangements. These arrangements cannot therefore be taken account of in our impact assessment. This has led to discrepancies in activity counts between joint pricing team and provider impact assessments.
- Changes in activity data. In some cases, it was identified that activity data in providers had been recoded and therefore no longer matched the data submitted to HES.
- Differences in activity included/excluded. There were some differences in activity counts where a provider had not excluded regular day case attenders.
- Issue with how trusts are recording and submitting activity for unbundled HRGs. As part of the EIA process an issue was raised regarding the difficulty providers can have linking scans to outpatient appointments due to the time lags between the appointment and the procedure.

Methodological issues:

- Specialist top-ups. The pricing team impact assessments applied the proposed changes to specialist top-ups. These changes were not in the PSS tool available to participants and led to differences in income calculations, particularly for some specialist providers.
- Although the 2019/20 EIA focussed only on activity and income for the 2019/20 tariff, the methodology remained unchanged. This caused some issues with activity counts for HRGs where there had been changes in ICD-10 codes. The 2019/20 EIA maintained the requirement for activity in an HRG to map back to the same HRG in the previous tariff. Therefore, in the

small number of instance where there had been changes to ICD-10 codes mapping to HRGs, the activity counts in the joint pricing team impact assessment did not reflect these changes.

- OPROC procedures with no price. As with previous years we have identified issues with the way participants recorded OPROC activity and prices. The process followed by the joint pricing team when an outpatient procedure didn't have a national price is to use the outpatient attendance price. The process followed by many of the participants when a price didn't exist was to move the activity to the outpatient section and use the outpatient price. The upshot of this was that although the same prices were being used, the activity and income was being held in different places. The joint pricing teams have checked their approach and believe it to be correct; we are therefore not proposing any changes to our impact assessment based on this issue.

Remaining differences

- Extra patients in particular sub-chapters (PB, EB, PV, FD and AA). After detailed investigations and cross-checking, activity calculations against different data sources (including SUS+). There are some instances where there are differences in activity counts that have not been explained. Further work is being proposed in this area.

Changes made

284. As a result of the differences identified we have made a number of changes to the current price modelling process. The activity calculations feeding the pricing calculation model were updated to remove critical care bed days and work has been undertaken to ensure that the correct organisation codes and MFF values are applied. This will be an ongoing piece of work that will need attention in future tariffs. The issue of the presentation of prices has also been considered by the pricing teams.

Conclusion

285. The EIA process is a valuable project that serves to fine tune our impact assessments. As discussed, the EIA identified a number of issues and we have made changes as a result, to both the impact assessment and price calculation processes.

Contact us:

NHS Improvement
Wellington House
133-155 Waterloo Road
London
SE1 8UG

0300 123 2257
pricing@improvement.nhs.uk
improvement.nhs.uk

NHS Improvement publication code: C 02/19