Monitor

Making the health sector work for patients

2016/17 National Tariff Payment System proposals: Impact assessment

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About Monitor

As the sector regulator for health services in England, our job is to make the health sector work better for patients. As well as making sure that independent NHS foundation trusts are well led so that they can deliver quality care on a sustainable basis, we make sure: essential services are maintained if a provider gets into serious difficulties; the NHS payment system promotes quality and efficiency; and patients do not lose out through restrictions on their rights to make choices, through poor purchasing on their behalf, or through inappropriate anti-competitive behaviour by providers or commissioners.

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Summary

Under the Health and Social Care Act 2012, Monitor and NHS England are jointly responsible for the National Tariff Payment System (NTPS).

Monitor and NHS England's proposals for 2016/17 are designed to provide financial stability for providers. The starting point for national prices is the Enhanced Tariff Option (ETO), which 88% of NHS providers adopted in 2015/16 through local variations to 2014/15 national prices. For 2016/17 Monitor and NHS England now propose national prices which would be an average increase of 1.8% to the ETO prices, taking account of efficiency, inflation, and increases to Clinical Negligence Scheme for Trusts (CNST) contributions.[1] They also propose to remove the specialised services marginal rate.

This report sets out Monitor's assessment of the likely impact of the proposals, including those for national prices.[2,3] It compares what would happen in 2016/17 if Monitor and NHS England implemented their proposals with what would happen if the current situation, where the 2014/15 NTPS remains in force and providers are receiving payment for nationally priced services based on the ETO or the default tariff rollover (DTR), were to continue. In general, our assessment assumes that healthcare activity remains constant at the level of the latest nationally-available activity data (2013/14 Hospital Episode Statistics). In addition to the direct impact of the proposals, it is anticipated that the overall effect of the proposed 2016/17 NTPS on DTR providers will be mitigated by the reintroduction of CQUIN if the 2016/17 NTPS proposals are brought into effect.[4] Where relevant, we note what the effect of this would be.

We have improved our assessment approach to take into account the findings of our recent enhanced impact assessment project. This project and its findings are discussed in more depth at **Annex 1**.

Many factors will affect provider finances in 2016/17. This includes payment for healthcare services under the NTPS, education and training funding, and the recently-announced Sustainability and Transformation Fund. Provider finances are also affected by changes in the costs they face.

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[1] The Clinical Negligence Scheme for Trusts (administered by the NHS Litigation Authority) indemnifies providers against clinical negligence claims.

[2] Unlike the statutory consultation notice, this impact assessment report is the statutory responsibility of Monitor alone. Therefore, throughout this report 'we' refers to Monitor, not to Monitor and NHS England.

[3] Our analysis is based on the prices published alongside the consultation notice, **not** the draft prices published on 22 December 2015.

[4] See Section 2.5 of Part B of the consultation notice.

This report focuses on the impact of the proposed changes to the NTPS, and so does not address these wider factors.

Overall financial impact on NHS providers

Finding 1: The proposals in the consultation notice, taken together with the reintroduction of CQUIN for DTR providers, would increase the operating revenue of almost all NHS providers. For ETO providers, the average operating revenue increase would be 1.6%. For DTR providers, the average increase would be 2%. Without the reintroduction of CQUIN, the average increase for DTR providers would be 0.1% of operating revenue. These figures include our assessment of how locally determined prices may change as a result of providers and commissioners having regard to the efficiency and cost uplift factors adopted under the ETO, as well as those that are proposed for 2016/17, when determining local prices.

Finding 2: For ETO providers, operating revenue would increase by between 0.5% and 2.3%.

Finding 3: For DTR providers, operating revenue would change by between -0.3% and +3.8%. Without the reintroduction of CQUIN, operating revenue would change by between -1.6% and +2.1%.

In Findings 4 to 10 we break down these figures, showing the financial impact of each of the main proposals in the consultation notice. These main proposals cover changes to national prices and currency design, changes to the marginal rates for emergency admissions and specialised services, and changes which are likely to affect the level of local prices.

Financial impact of individual proposals

Finding 4: On average, the proposed new national prices and currency design (including the adjustments for inflation, efficiency and CNST) would increase the nationally-priced revenue of ETO providers by around 1.9% (equivalent to 1.1% of operating revenue). For individual providers the impact ranges between 0.0% and 1.8% of operating revenue.

Finding 5: On average, the proposed new national prices and currency design would increase the nationally-priced revenue of DTR providers by around 0.5% (equivalent to 0.2% of operating revenue). For individual providers the impact ranges between -1.2% and +2.3% of operating revenue.

Finding 6: On average, the proposed new national prices would increase the nationally-priced revenue of independent providers by around 1.6%.

Finding 7: On average, the proposed new national prices would increase CCG spending by around 0.8% of their total allocation. CCGs commissioning activity

from DTR providers are more likely see a reduction in spending on nationally-priced services.

Finding 8: Making the marginal rate for emergency admissions 70% (rather than 30%) would increase the revenue of DTR providers by around £15 million (<0.1% of their operating revenue). It would not affect ETO providers, as the 70% marginal rate already applies to them.

Finding 9: Removing the specialised services marginal rate would increase the revenue of ETO providers by around £65 million (around 0.1% of their operating revenue). Around half of this (£30 million) would be received by teaching hospitals, who offer the largest range of specialised services. Removing the marginal rate would not affect DTR providers, who are not currently subject to it.

Finding 10: We estimate that the proposals would increase local prices by 1.1% on average for ETO providers, and 0.3% for DTR providers. Providers and commissioners would be required to have regard to the efficiency and cost uplift factors in the ETO and under the proposals for 2016/17 when setting local prices. In particular, DTR providers also need to have regard to the efficiency and inflation factors included in the ETO, and we estimate this would decrease their locally-priced revenue by around 0.8%.

Equalities and competition

Finding 11: The proposals are unlikely to have a disproportionate impact on any group with a protected characteristic under the Equalities Act. Holding total activity and spending constant, nationally-priced spending on patients in every age, gender and ethnic group would change by less than +/-2%. While we cannot quantify the impact of the proposed prices for groups with other protected characteristics, we consider it is unlikely to differ substantially from group to group.[5] We consider that the other proposals are unlikely to have a material disproportionate impact for any group with a protected characteristic.

Finding 12: The proposals are unlikely to have a significant impact on patient choice and competition. While the proposals could in principle have various impacts on competition (both positive and negative), we consider that none are likely to be substantial.

[5] The protected characteristics are age, gender, race, pregnancy and maternity, disability, gender reassignment, sexual orientation, marriage and civil partnership, and religion (including not having a religion).

Background

Monitor and NHS England's proposals for the 2016/17 NTPS are designed to provide financial stability for providers. The starting point for the proposed national prices are the prices adopted under the Enhanced Tariff Option (ETO), which 88% of NHS providers are already using. These prices would be increased by 1.1% to take account of efficiency and inflation, and further increased by an average of 0.7% to take account of likely increases to Clinical Negligence Scheme for Trusts (CNST) contributions.[6,7] Monitor and NHS England also propose to remove the specialised services marginal rate.

This report sets out our assessment of the likely impact of the NTPS proposals, including those for national prices. Unlike the consultation notice, this report is the statutory responsibility solely of Monitor.[8] Throughout this report 'we' refers to Monitor alone, not Monitor and NHS England. CQUIN is not part of the NTPS. However, we anticipate that NHS England will reintroduce CQUIN for providers who opted for the DTR if the 2016/17 NTPS proposals come into effect.[9] Where relevant, we note what the effect of this would be.

1.1. Our assessment approach

In conducting our assessment, we have followed the principles in our impact assessment framework.[10,11] We have aimed to make our assessment of each policy **proportionate**, **transparent**, **evidence-based**, **specific to the policy**, **compared to an appropriate baseline**, and **robust to key assumptions**.

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

Whatever the method, all sections of this assessment seek to achieve the same goal. They compare what would happen in 2016/17 if Monitor and NHS England implement their proposals, with the current situation, where the 2014/15 NTPS remains in force and providers receive payment for nationally priced services based on the ETO or the DTR. Where relevant, our assessment assumes that healthcare

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[6] The ETO was agreed by these providers and their commissioners as a local variation.
[7] The Clinical Negligence Scheme for Trusts (administered by the NHS Litigation Authority) indemnifies providers against clinical negligence claims.
[8] Monitor is required to publish this assessment by Section 69 of the Health and Social Care Act 2012.
[9] See Section 2.5 of Part B of the consultation notice
[10] Monitor 2014, *2015/16 National Tariff Payment System: Impact assessment framework*.
[11] We also had regard to general guidance (such as *HM Treasury 2011, The Green Book - Appraisal and Evaluation in Central Government*) where appropriate, as required by Section 69(6) of the Health and Social Care Act 2012.

activity remains constant at the level of the latest nationally-available activity data (2013/14 Hospital Episode Statistics).

We have improved our assessment approach to take into account the findings of our enhanced impact assessment. In August, we published our initial proposals on currency design and relative prices, and also our preliminary assessment of their impact. Since then, we have gathered feedback on the preliminary impact assessment from a representative group of providers. Through this process we found several ways to improve our assessment approach, and where relevant we have included these improvements in the analysis underlying this report. We describe the enhanced impact assessment project in **Annex 1**.

1.2. This report

This report is structured as follows:

- **Section 2** assesses the impact of proposals for national prices.[12]
- **Section 3** assesses the impact of proposals for national variations.[13]
- **Section 4** assesses the impact of not proposing a marginal rate rule for specialised services.[14]
- **Section 5** assesses the impact of proposals for changes to locally-determined prices.[15]
- **Section 6** combines these assessments to show the total financial impact of the proposals, and also notes the potential impact of CQUIN.
- In **Sections 7 and 8** we assess the impact of the proposals on equalities and competition.

We do not describe the proposals in depth in this report, to avoid repeating the consultation notice. A number of respondents to the 2015/16 statutory consultation notice felt the notice and its supporting documents were unnecessarily long, partly because of repetition between them. This report aims to provide enough detail on each policy for the reader to be clear on what is being assessed. All of Monitor and NHS England's policy proposals are described in the consultation notice, and we suggest reading this report alongside it. The consultation notice also describes the reasons why Monitor and NHS England are proposing each policy. Each section of this report includes a reference to the relevant section of the consultation notice.

[12] These proposals are described in Sections 6 and 7 of the consultation notice.
[13] These proposals are described in Section 8 of the consultation notice.
[14] As a marginal rate rule does not form part of Monitor and NHS England's proposals it is not explicitly discussed in the consultation notice. We discuss it in this impact assessment because not having a marginal rate rule is a change from the current situation, where a marginal rate rule is in force for ETO providers.
[15] These proposals are described in Section 9 of the consultation notice.

Many factors will affect provider finances in 2016/17. This includes revenue for healthcare services under the NTPS, but also other sources of revenue such as payments for education and training, research and public health. It also includes all the factors which affect provider costs, such as inflation and regulatory requirements. A new factor is the Sustainability and Transformation Fund which NHS Improvement,[16] NHS England and the Department of Health recently announced. The purpose of the Sustainability and Transformation Fund is to help challenged hospitals to achieve financial balance while focusing on changing the way they provide high quality care for patients. This report focuses on the impact of the proposed changes to the NTPS, and so does not discuss these wider factors.

[16] NHS Improvement brings together Monitor, the NHS Trust Development Authority and groups from three other organisations: from NHS England the Patient Safety Team and the Advancing Change Team, from NHS Interim Management and Support two Intensive Support Teams, together with the National Reporting and Learning System. NHS Improvement is an operational name for the organisation which formally comes into being from 1 April 2016.

2. National prices and currency design

For 2016/17, Monitor and NHS England are proposing to set national prices based on the prices and currency design in the ETO, with adjustments for inflation, efficiency and CNST which will increase them by 1.8% on average. Monitor and NHS England also propose to make manual adjustments to the prices for a small number of HRGs, in response to sector feedback.[17]

2.1. Methodology

The quantitative analysis in this section simulates payments under the proposed national prices and currencies and compares them to payments under current prices (ie the 2014/15 prices or those prices varied under the ETO).[18,19] It uses this to assess the financial impact of the proposed prices and currency design on providers and commissioners. It does not consider the effects of CQUIN, which we note in Section 6.

This analysis assumes that healthcare activity remains constant at the level of the latest nationally-available activity data (2013/14 Hospital Episode Statistics). We recognise that in reality providers and commissioners may want to alter activity levels or how services are commissioned in response to the proposed prices. However, we consider that analysis which assumes constant activity is the best way to help readers understand the proposed price changes. Activity changes would also be challenging to predict.

This analysis also excludes a small amount of activity, in light of the findings from our enhanced impact assessment project. This found that when we included activity that was newly in the scope of national prices, or was substantially affected by changes to the high cost drugs and devices list, it was not fully comparing like with like. We have therefore excluded such activity from our analysis. This is discussed in more detail in **Annex 1**.

There are a small number of price changes which we have excluded from this analysis, and instead assessed qualitatively. This is because we do not hold the activity data necessary to simulate payments for these prices.

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[17] These proposals are described in Sections 6 and 7 of the consultation notice.

[18] The quantitative analysis presented in this section covers admitted patient care, outpatient procedures, outpatient attendances, and A&E. It excludes prices for 'unbundled' services, 'other mandatory' prices and non-mandatory prices. It treats best practice tariffs in the same way as SUS PbR; this means that for some best practice tariffs it assumes the best practice price applies, and for others that the non-best practice prices applies. Details of how SUS PbR treats best practice tariffs are available in the National Tariff Information Workbook.

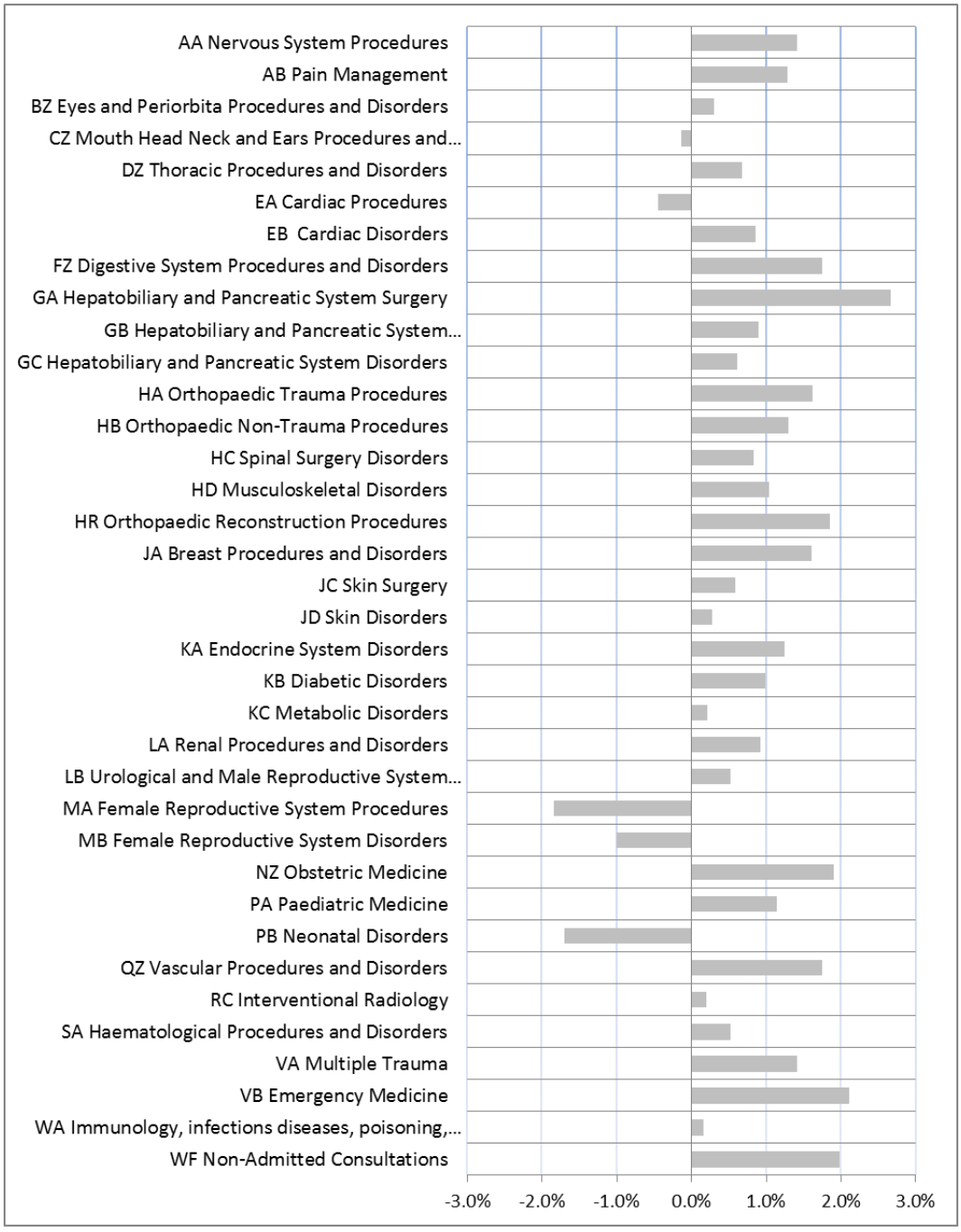
[19] Our analysis is based on the prices published alongside the consultation notice, **not** the draft prices published on 22 December 2015.

We have also assessed the impact of the proposed prices and currencies on patients qualitatively. In doing so, we have taken account of the benefits which Monitor and NHS England consider are likely to occur from making national prices more stable.

2.2. Impact by type of care

The proposals would cause spending on most types of care to increase. The variation in spending change between types of care is driven by two factors; variation in CNST uplifts, and variation in the extent to which a type of care is provided by DTR providers. **Figure 1** shows changes in total spending for different types of care.

Figure 1: Change in total spending for different types of care



2.3. Impacts on providers

Here we consider the impact of proposed prices on both NHS and independent sector providers.

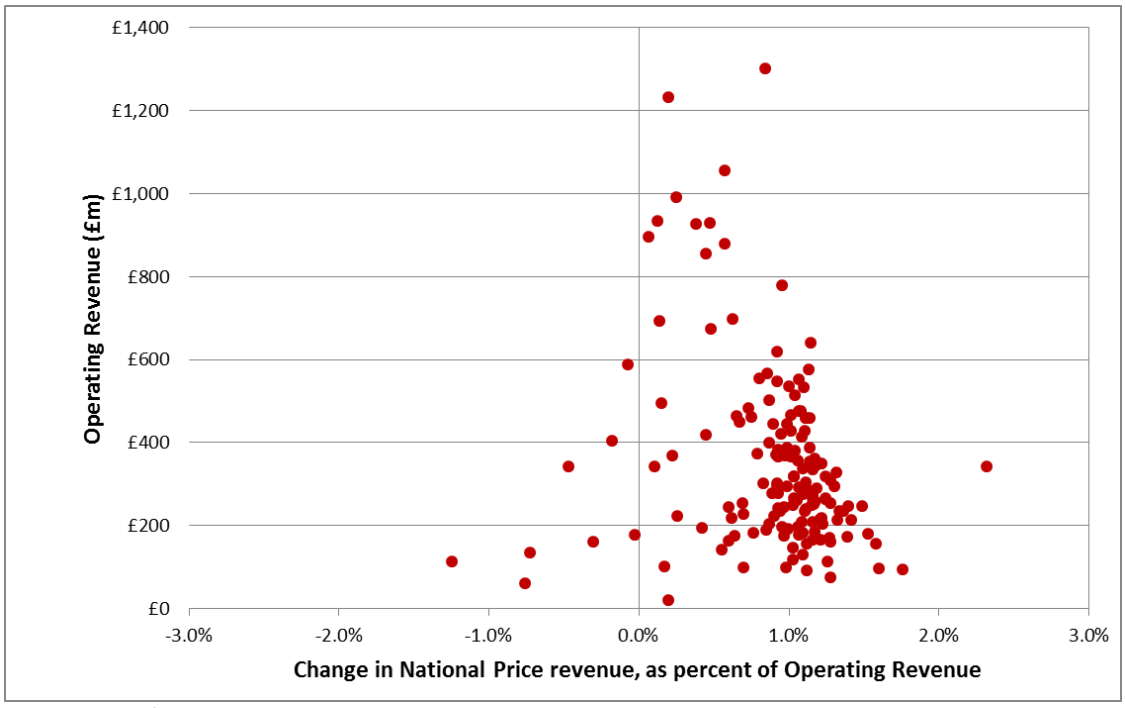
2.3.1. NHS providers

The proposals would increase the nationally-priced revenue of NHS providers on the ETO by around 1.9% (1.1% of operating revenue) on average. For individual ETO providers the impact varies from 0.0% to 1.8% of operating revenue.[20]

They would increase the nationally-priced revenue of DTR providers by 0.5% (0.2% of operating revenue) on average. For individual DTR providers the impact varies from -1.2% to +2.3% of operating revenue.

Figure 2 below illustrates the estimated financial impact of the proposed prices on all NHS acute providers.[21,22]

Figure 2: Overall impact on provider revenue of changes to national prices



Source: Monitor

[20] The impact of the proposed prices on ETO providers varies for two reasons. First, different providers receive different proportions of their operating revenue from nationally-priced services. Second, different CNST uplifts are applied to national prices in different specialties, according to each specialty's risk of clinical negligence claims. This means the impact of CNST uplifts will vary slightly depending on which specialties providers offer.

[21] We have excluded non-acute providers from this graph as only a small proportion of their operating revenue (6.5%) comes from nationally-priced services.

[22] The provider with the largest increase has been involved in a merger; the exceptional increase in its nationally-priced revenue is because it now has a higher MFF following the merger.

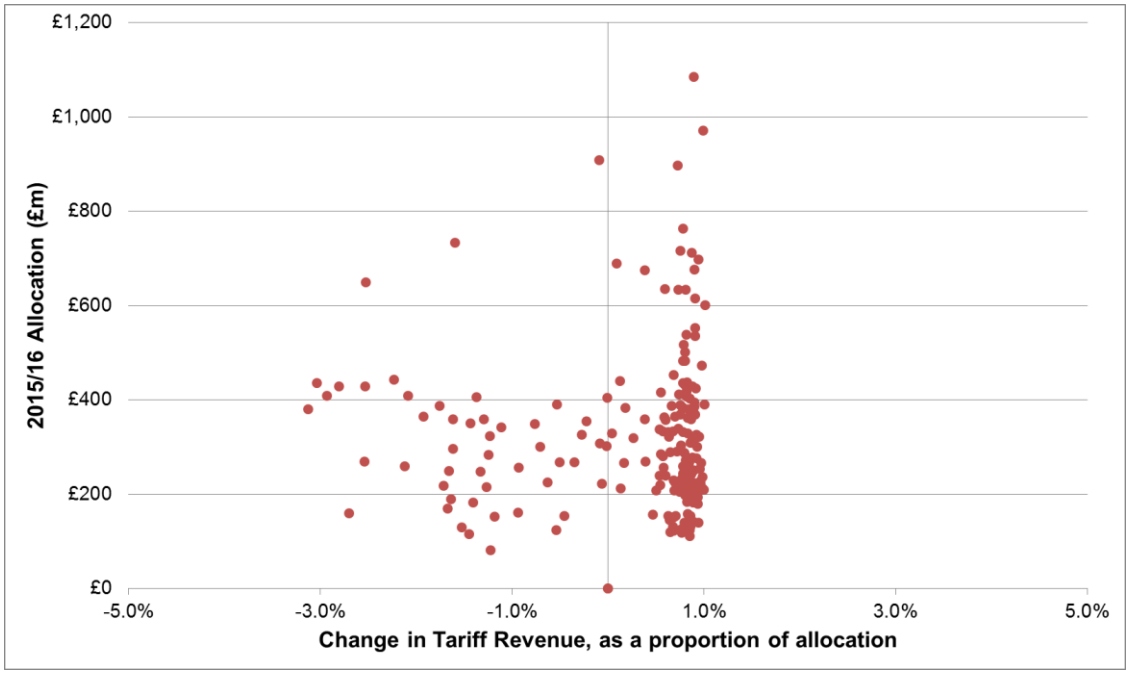
2.3.2. Independent providers

On average, the nationally-priced revenue of independent providers would increase by around 1.6%. 90% of providers would see an increase in their nationally-priced revenue. Nationally-priced revenue will typically be a smaller part of independent provider operating revenue than of NHS provider operating revenue.[23]

2.4. Impact on commissioners

Overall, the proposals would increase clinical commissioning group (CCG) spending by around £450 million (0.8% of allocations).[24] Within this, the spending of 73% of CCGs would increase, while the spending of the remaining 27% of CCGs (those who commission more from DTR providers) would fall. **Figure 3** below shows the distributional impact of the proposed prices on CCGs, measured as a percentage of their total allocation for 2016/17.

Figure 3: Impact of proposed changes to national prices on commissioner spending[25]



Source: Monitor

We estimate that there will be a reduction of less than £5 million in the expenditure of NHS England, compared to the arrangements in place in 2015/16.

[23] Our analysis of the impact of proposed prices on independent providers assumes that they are all currently receiving DTR prices.

[24] For a small number of CCGs these changes are partly driven by changes to the MFF of their primary provider, following restructuring.

[25] This analysis shows the distributional impact of changes to prices in APC, OP and A&E. It does not include Maternity or Unbundled.

2.5. Qualitative assessment of proposed price changes

We have not assessed a number of prices quantitatively. This is because for these prices we do not hold the activity data necessary to simulate payments. For these prices we have only carried out a qualitative assessment. These prices fall into two groups: other national prices and non-mandatory prices.

2.5.1. Other national prices

Other national prices cover four groups of services:

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

Monitor and NHS England propose to set prices for these services based on ETO prices with adjustments for inflation, efficiency, and CNST (where relevant). This means the proposed prices are between 0 and 1.6% higher than current ETO prices. They are between 2.7% lower and 0.3% higher than DTR prices. **Figure 4** below shows the full set of proposed price changes.

Figure 4: Other national prices

			DTR to proposed 16/17 tariff	ETO to proposed 16/17 tariff
Group of Service	HRG code (if applicable)	HRG name/Description/Band/Task	Tariff (change %)	Tariff (change %)
Direct access services	FZ54Z - Flexible Sigmoidoscopy	Diagnostic Flexible Sigmoidoscopy 19 years and over	0.3%	1.3%
	FZ55Z - Flexible Sigmoidoscopy	Diagnostic Flexible Sigmoidoscopy with biopsy 19 years and over	0.0%	1.2%
	DZ35Z - Airflow Studies	Simple Bronchodilator Studies	0.0%	1.4%
	DZ44Z - Airflow Studies	Simple Airflow Studies	-2.7%	0.0%
Rehabilitation post discharge		Knee Replacement	-0.5%	1.4%
		Hip Replacement	-0.6%	1.3%
		Cardiac	-0.7%	1.3%
		Pulmonary	-0.6%	1.3%
Cystic fibrosis		1	-0.6%	1.3%
		1A	-0.6%	1.4%
		2	-0.6%	1.4%
		2A	-0.6%	1.4%
		3	-0.6%	1.4%
		4	-0.6%	1.4%
		5	-0.6%	1.4%
Looked after children's health assessments		Out-of-area Initial Health Assessment	-0.7%	1.4%
		Out-of-area Review Health Assessment	-0.4%	1.6%

Source: Monitor analysis

The impact of these proposed prices should be similar to the impact of the other proposals discussed above. We expect that they will increase the revenue of all ETO providers, and slightly increase or decrease the revenue of DTR providers depending on the mix of services they offer.

2.5.2. Non-mandatory prices

NHS England and Monitor have proposed to introduce non-mandatory prices to inform local negotiations for the following services, already introduced for providers currently on ETO:

- complex therapeutic endoscopy
- dialysis for acute kidney injury
- photodynamic therapy.

This proposal will help commissioners to make better-informed decisions, because the prices are based on the costs of all relevant NHS providers and are therefore a more reliable benchmark of efficient costs than locally negotiated prices, and will send a clearer signal of the efficient cost of each service. Currently, CCGs and providers negotiate prices based on their own views of efficient costs.

We also expect that existing non-mandatory prices will remain useful as guidance for providers and commissioners in 2016/17.

2.6. Potential impact on patients

We expect that keeping the relationship between different prices broadly the same as in the ETO would bring some benefits for patients of ETO providers. For example, we expect that it would make it easier for providers and commissioners to plan and to agree contracts. Earlier agreement on what services are to be delivered is likely to make provision of those services more effective.

However, there are also risks to patients of ETO providers from keeping prices stable. The more years prices are rolled over, the less they reflect the current costs of providing services (even if uniform inflation uplifts are applied), and this could negatively affect patients. For example, if the cost of providing a service increases, but prices are not updated to reflect those costs, it might become financially unviable for providers to offer that service.[26] These effects increase the more years prices are rolled over, though may be mitigated by falls in other costs.

For patients of DTR providers, we expect the impact of changing the relationship between prices will vary. As ETO prices are based on more up-to-date data, we would expect the relationship between them to be more reflective of true cost

[26] This risk is reduced for Commissioner Requested Services, which providers cannot cease to offer without agreement from their commissioner or, failing that, from Monitor.

differences than is the case for DTR prices. In general, we expect more cost-reflective prices would encourage greater productive efficiency (delivery of services for lower cost) and allocative efficiency (delivery of a better mix of services), both of which would benefit patients. However, there is a risk that for where prices for a service have fallen relative to other services, some providers may respond by stopping the service or reducing its quality

Increasing the overall level of prices could benefit patients. Price increases mean that prices are more likely to cover the full costs of providing care. This could mean that providers are less likely to reduce care quality in order to make their costs lower than prices. However, it does also mean that commissioners will be able to afford to commission less care than if prices were lower, which could negatively affect any patients requiring care which is not commissioned.

In general it is challenging to assess how the proposed prices will affect patients. Ultimately, prices affect patients by influencing provider and commissioner decisions about patient care. It is not easy to predict those decisions, or to understand how much they are driven by price changes rather than other factors. We hope to do more work in future to assess the impact of prices on patients.

3. National variations

Monitor and NHS England propose to modify an existing national variation and remove a number of others. This will not have any impact on ETO providers. It would impact DTR providers (and their commissioners) in two different ways: by changing the emergency admissions marginal rate rule they are subject to, and by removing four transitional national variations. We discuss each of these in turn.

3.1. Emergency admissions marginal rate

The marginal rate emergency rule was introduced in 2010/11 in response to a growth in emergency admissions in England that could not be explained by population growth and A&E attendance growth alone. It is intended to incentivise:

a. lower rates of emergency admissions

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

The marginal rate rule sets a baseline monetary value for emergency admissions at a provider.[27] A provider is then paid a percentage of the national price for any increases in the value of emergency admissions above this baseline.

For 2016/17, Monitor and NHS England propose to set that percentage at 70%. This is the same as in the ETO, but an increase from the 2014/15 NTPS percentage of 30% (which applies to DTR providers).

The best data we have for assessing the impact of this change is 2015/16 CCG plans. When applying the marginal rate rule, providers and commissioners should agree a baseline which is based on 2008/09 emergency admissions but also has been adjusted, where necessary, to account for significant changes in the pattern of emergency admissions faced by providers (for example due to mergers). We do not hold data on the baselines agreed locally by providers and commissioners. However, 2015/16 CCG plans submitted to NHS England were required to state how much money they expect to retain due to the marginal rate rule. We used these plans to estimate what the impact of changing the percentage would be.

We estimate that if healthcare activity remains constant, setting the marginal rate percentage at 70% will increase the revenue of DTR providers by around £15 million (<0.1% of operating revenue), and increase the spending of their commissioners by a corresponding amount.

This adjustment would strengthen the incentive on commissioners to work to reduce avoidable emergency admissions, which would be to the ultimate benefit of patients.

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[27] As defined in the NHS Data Model and Dictionary. These codes are: 21-25, 2A, 2B, 2C or 2D (or 28 if the provider has not implemented CDS 6.2).

On the other hand, commissioners are already required to spend the money they retain due to the marginal rate rule on schemes for reducing emergency admissions; making the marginal rate more in favour of providers may reduce the funds commissioners have for such schemes.

3.2. Transitional national variations

Monitor and NHS England are proposing that the 2016/17 NTPS not include four previous transitional national variations. They relate to the maternity pathway, unbundled diagnostic imaging in outpatients, chemotherapy delivery and external beam radiotherapy. Monitor and NHS England included these variations in the 2014/15 NTPS to allow the sector time to adapt to new payment approaches in these areas. The variations were not part of the ETO.

We consider that DTR providers and their commissioners have now had sufficient time to adapt to the new payment approaches, and therefore these variations are no longer necessary. In view of the time they have had to adapt, we expect removing the variations will not have any significant impact.

4. Specialised services marginal rate

The ETO includes a marginal rate rule for acute prescribed specialised services. This rule shares the financial risk of growth in acute specialised services spending between providers and NHS England. Broadly, providers have been paid 70% of the difference between the stated base value and the gross specialised contract value for 2015/16.This means that if activity or cost growth makes a provider's revenue higher than the base value, NHS England only pays for 70% of the growth. Conversely, it means that if providers can reduce activity and costs below the stated base value, they are paid 70% of the saving this has created for NHS England.

Monitor and NHS England are proposing not to include this marginal rate in the 2016/17 NTPS, in light of sector feedback. NHS England will however continue to drive efficiencies in spending on specialised services, for example through a move to centralised procurement of devices.

Not including the marginal rate will have no impact on DTR providers, as they are not currently subject to a marginal rate. It will however affect ETO providers.

We assessed the impact on ETO providers of removing the marginal rate rule using 2015/16 planning data. This data specifies how 2015/16 contract revenue has been affected by the rule, and we consider this provides a reasonable guide to what the impact of removing the rule in 2016/17 would be. The exact impact may differ slightly from this, as it will be affected by any differences between 2015/16 and 2016/17 specialised services contracts, which we do not have the data to model.

Overall, we estimate that removing the specialised services marginal rate will increase ETO provider revenue (and NHS England spending) by around £65 million. The impact on individual providers depends on both how much specialist work they carry out, and how this compares with their baseline.[28] **Figure 5** shows the impact of the change on different types of provider.

Figure 5: Impact on ETO providers of removing the marginal rate rule

Provider type	Impact (£ million)	Impact (% of operating revenue)
Acute large	14	0.1%
Acute medium	8	0.1%
Acute small	5	0.1%
Acute specialist	6	0.2%
Acute teaching	30	0.2%
Ambulance	0	0%
Community	0	0%

[28] Around two thirds of providers who offer any specialised services offer less than ten such services.

Provider type	Impact (£ million)	Impact (% of operating revenue)
Mental health	0	0%
Multiservice	1	0.2%
Total provider impact	65[29]	0.1%

Source: Monitor analysis

Acute teaching hospitals will benefit most; their revenue will increase by around £30 million. This is related to the fact that they offer the greatest number of specialised services. Ambulance, community and mental health providers will be largely unaffected, as they provide few specialised services where the marginal rate rule would apply.

Specialised services patients are likely to benefit from this change, as higher reimbursement could enable better quality care and shorter waiting times.

However, there may be negative effects on patients of other services. When Monitor and NHS England originally proposed the marginal rate rule for the 2015/16 NTPS, they noted that spending on specialised services was growing rapidly, and that they were concerned this was not in line with the best allocation of scarce resources for patients. The marginal rate was partly an attempt to stem this growth. Removing the marginal rate may have the effect of transferring NHS resources away from patients of non-specialist services, which could reduce the quality of their care or increase their waiting times.

There may be a differential impact on patients with certain characteristics that are protected under the Equalities Act, as patients with certain equalities characteristics are more likely to require specialised services. We discuss this in more detail in **Section 7**.

[29] Figures do not sum exactly due to rounding.

5. Locally Determined Prices

Less than half of spending within the scope of the NTPS is nationally-priced. The remainder is covered by local pricing arrangements.

In addition, providers and commissioners can choose to depart from national prices in two ways. The first, 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. The second, local modifications, are where providers are paid a higher price because they can demonstrate to Monitor that there are structural reasons why it would be uneconomical for them to provide a service at the national price.

The NTPS includes rules governing local variations and local prices and methods for determining local modification applications or agreements (jointly referred to as locally determined prices). We are proposing to make six main changes to the rules governing locally determined prices:

- Clarify guidance on the general rules governing local prices. This is very similar to guidance we proposed for the 2015/16 NTPS.
- Set a deadline of 30 June for commissioners to notify Monitor of local variations that are included in contracts, and within 30 days for variations that are agreed after that date.
- Set a deadline of 30 September for providers to make local modification applications, unless there are exceptional circumstances.
- Clarify existing local pricing rules for mental health services.
- Require that the price agreed between commissioners and providers for high cost devices must be either the price the provider would have paid had it used a supplier or framework nominated by the commissioner, or the price the provider actually paid, whichever is lower. In setting locally determined prices the proposal is that commissioners and providers would be required to have regard to the efficiency and cost uplift adjustments adopted under the ETO as well as the efficiency factor and cost uplifts proposed for 2016/17.

5.1. Guidance on local prices

We consider that clarifying guidance for local price-setting is likely to help local price-setting function more effectively. It will mean commissioners and providers are in a better position to understand what is expected of them, which should encourage best practice in local price-setting.

5.2. Local variations

We consider that setting a 30 June deadline for commissioners to notify Monitor of local variations included in contracts is likely to help the local variations system function more effectively. Compared with the current situation (where 80% of local

variations are submitted to Monitor after September), Monitor will, where appropriate, be able to give guidance earlier on any changes needed to ensure compliance with the rules.

5.3. Local modifications

We consider that setting a 30 September deadline for providers to notify Monitor of local modification applications is likely to reduce the risk that local modifications might otherwise pose to commissioner finances. It will enable commissioners to adjust plans and budgets for the following year, in line with the commissioning timetable.

While this proposal does present a risk that some providers who would otherwise be eligible for a local modification will not receive one due to missing the deadline, we consider that overall this proposal strikes an appropriate balance between allowing enough time for providers to develop an application and commissioners to plan and manage any uplift in prices.

5.4. Mental health

Payment for mental healthcare is subject to local payment arrangements. There are national currencies (the mental health clusters), but no national price. Consistent with current guidance, many commissioners pay for mental healthcare based on the mental health clusters. However, some commissioners and providers are still using block contracts, whose values are largely based on historic contract values rather than an assessment of current patient needs and consideration of what service model and resources will meet that need in an efficient and effective way.

We have proposed to clarify existing local payment rules regarding payment approaches for mental health and data reporting requirements. Under the proposed local payment rules, it would still be possible for commissioners and providers to agree an alternative payment approach, as long as that approach is consistent with the current arrangements for agreeing a price without using a national currency.

We consider that this change should help the sector better understand our expectations on mental health payment and reporting. This will help ensure payment for mental healthcare is evidence-based and supports good quality care. We do not expect any risks associated with these proposals.

5.5. High cost devices

We expect that this rule change will benefit commissioners, because it will enable them to pay for devices based on nationally-procured prices, which will often be lower than locally-procured prices.

We expect that providers will in general respond to this rule change by switching to the device supplier or framework nominated by their commissioner, or another,

cheaper, supplier. If they do this their revenue for high-cost devices will equal their expenditure, as now, and the only immediate impact on them will be the small administration cost of switching supplier.

In the longer term patients will benefit from commissioners saving money on high cost devices, because it will mean they have more to spend on other services for patients.

5.6. Price levels

In agreeing locally determined prices providers and commissioners are required to have regard to the efficiency and inflation factors used for national prices.

As we discuss in Section 2, we have used efficiency and inflation adjustments for national prices which have the combined effect of increasing ETO prices by 1.1%. We consider it likely that this will cause locally determined prices for ETO providers to increase by an average of 1.1% as well.

For DTR providers the effect would be different because they will need to have regard to two years of inflation and efficiency adjustments. As well as the inflation and efficiency adjustments for 2016/17 proposed by Monitor for national prices, they will also need to have regard to the inflation and efficiency adjustments for 2015/16 used in calculating the prices adopted under the ETO, which involved a 1.6% reduction.

We do not have sufficient data to assess how commissioners and providers on the DTR addressed locally determined prices in 2015/16. We assume that they have already partially adjusted for the full reduction.

In order to account for this uncertainty we have modelled DTR providers as having a 0.8% reduction in their locally priced revenue from this effect, which means that overall their locally-priced revenue would increase by 0.3%.[30,31] The scale of this impact on each provider will vary according to the proportion of the operating revenue that comes from locally priced services, and on the local prices they have agreed in 2015/16.

[30] The true effect will be a reduction in locally-priced revenue between 0% and 1.6%; 0.8% is the midpoint of this range

[31] 0.3% is 1.1% minus 0.8%

6. Combined financial impact on NHS providers

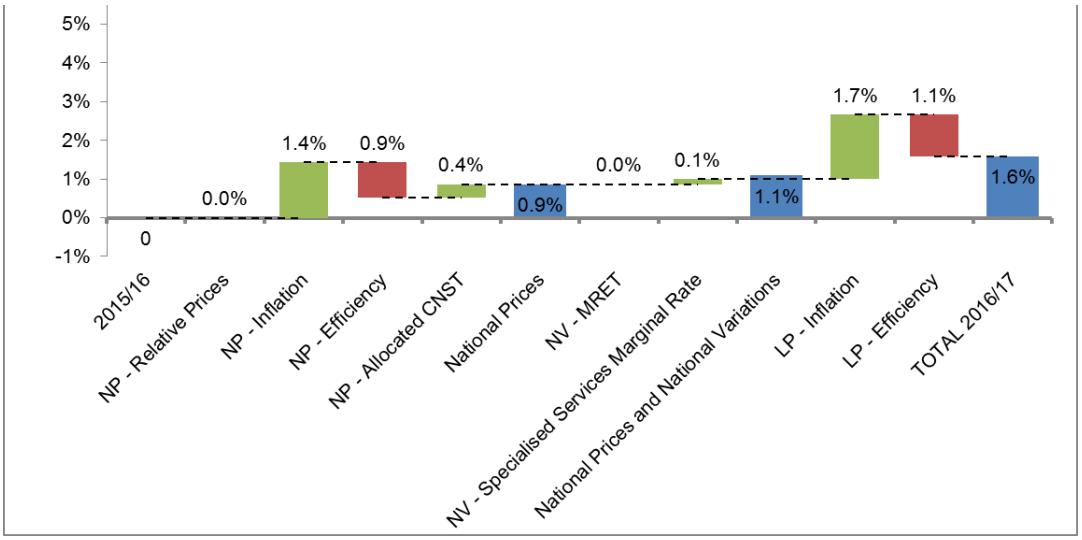
In this section, we estimate the combined financial impact on NHS providers of all of Monitor and NHS England's NTPS proposals for 2016/17 noting the effect of the reintroduction of CQUIN by NHS England for DTR providers. To do this, we bring together our assessments from Sections 2 to 5 of this report and, for DTR providers, add on the impact of reintroducing CQUIN funding.

We have based our estimate of the impact of reintroducing CQUIN on the actual CQUIN payments which each DTR provider received in 2014/15 (the last year they were paid CQUIN). This means that we implicitly assume that each provider's CQUIN requirements, and success at delivering them, will remain the same as in 2014/15. Actual CQUIN arrangements are currently being agreed between commissioners and providers, and so final CQUIN payments may be different to our estimates. As this report focuses on changes in provider revenue, we have also not taken into account any additional costs which providers may incur to meet their CQUIN requirements.

6.1. Overall impact – ETO providers

Overall, we estimate that the NTPS proposals would increase ETO provider operating revenue by 1.6% (ETO providers would be unaffected by the reintroduction of CQUIN). We show the contribution of the different policies to this in **Figure 6**.

Figure 6: Overall impact on ETO provider operating revenue

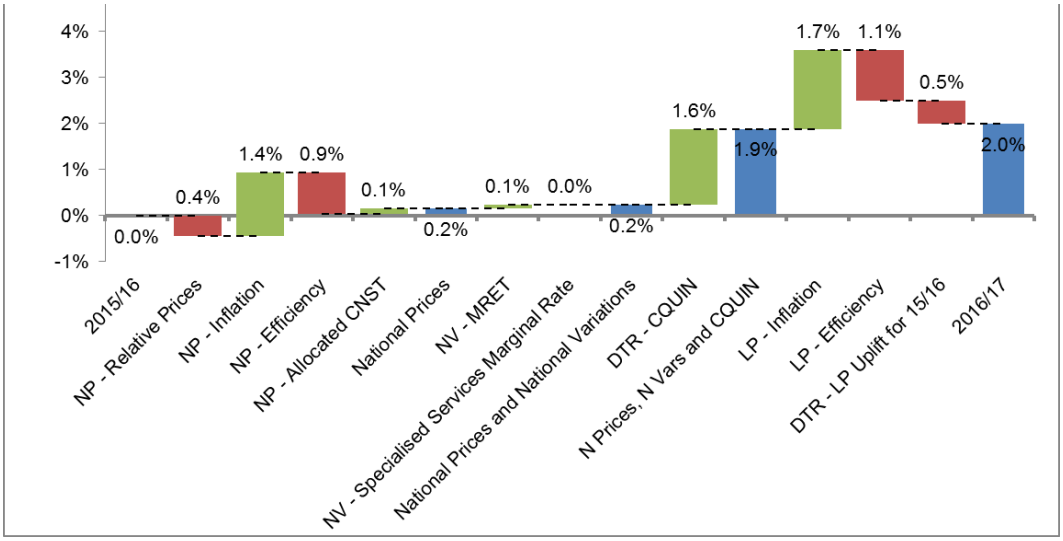


Source: Monitor analysis, NP: National Prices, NV: National Variations, LP: Local Prices. Figures may not sum due to rounding.

6.2. Overall impact – DTR providers

Overall, we estimate that the NTPS proposals, DTR providers incorporating the 2015/16 uplift into local prices and the reintroduction of CQUIN would increase DTR provider operating revenue by 2%. We show the contribution of the different policies to this in **Figure 7**.

Figure 7: Overall impact on DTR provider operating revenue

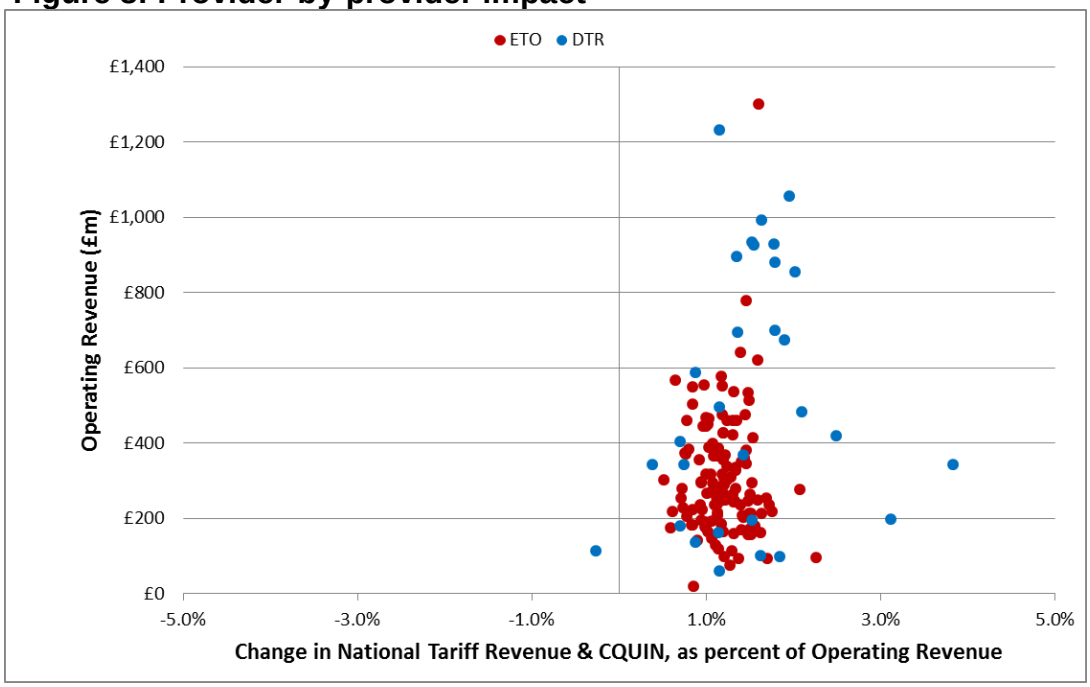


Source: Monitor analysis, NP: National Prices, NV: National Variations, LP: Local Prices. Impact of CNST is different than for ETO providers due to differences in casemix. Figures may not sum due to rounding.

6.3. Distribution of impact at provider level

We estimate that the NTPS proposals and the reintroduction of CQUIN would, taken together, increase the revenue of all but one NHS provider. The operating revenue of individual providers would change by between -0.3% and +4.1%. **Figure 8** shows the distribution of the impact on all NHS providers.

Figure 8: Provider-by-provider impact



Source: Monitor analysis

7. Equalities

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

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

In relation to paragraph (b), having due regard to the need to advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to:

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

With a view to complying with that duty, we have considered the potential impact of the policies proposed in the consultation notice on people with certain protected characteristics, compared with those who do not share them, including the extent to which the proposals may affect the disadvantages suffered by those individuals or the extent to which the NHS services subject to the payment system address their needs. The protected characteristics are:

- age
- race (including ethnic or national origins, colour or nationality)
- sex
- disability
- sexual orientation
- pregnancy and maternity
- gender reassignment
- marriage and civil partnership
- religion or belief (including lack of religion or belief).

In this section, we present our assessment of those potential impacts, which combines quantitative and qualitative analysis.

Patient age, race and sex are all recorded in 2013/14 Hospital Episode Statistics, so we have been able to quantify how proposed changes to national prices would affect spending on patients in different age, race and sex groups. This analysis assumes activity remains constant.[32] **In contrast with the quantitative analysis presented in other sections of this report, the analysis in this section also scales the proposed prices so that total nationally-priced spending remains constant.[33]**

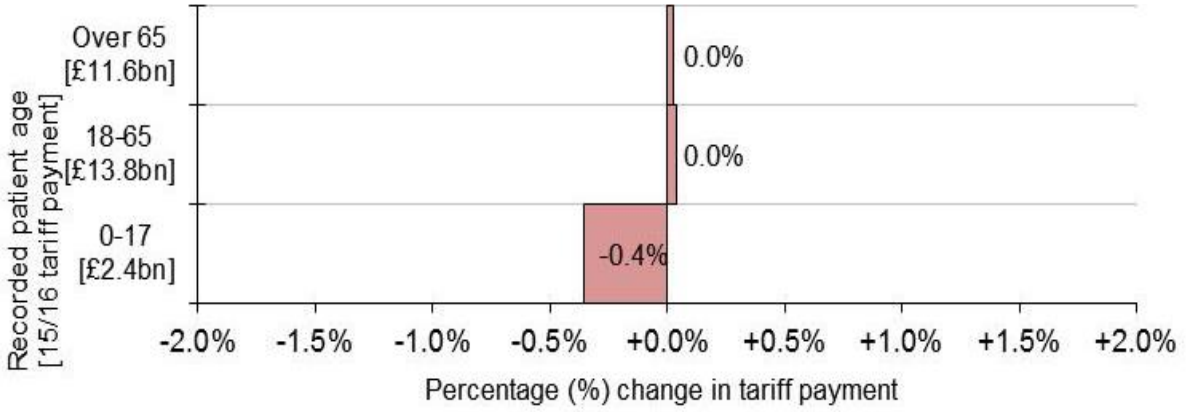
Other protected characteristics are not recorded in Hospital Episode Statistics, so for these characteristics we have conducted a wholly qualitative analysis.

Age

Age can have a major impact on length of stay and the costs of an intervention. Where appropriate, the currencies include an age split that reflects these cost differences.

We estimate that, if total spending and activity were held constant, the proposed prices would change nationally-priced spending on all age groups by <0.4%. **Figure 9** shows the change in spending for different age groups. Total spending on patients in the 18-65 and over 65 age groups would be almost unchanged, while total spending on 0-17s would decrease by 0.4%.

Figure 9: Change in spending by age group



Source: Monitor analysis

We have not identified any other aspects of the proposals which we expect to have a material disproportionate impact on any particular age group.

[32] Our analysis compares the relative (scaled) price change of the proposed 2016/17 national tariff (based on HRG4 currencies and 2013/14 reference costs) with the 2015/16 payment system (DTR based on HRG4 currencies and 2010/11 reference costs, and ETO 2014/15 modified prices based on provider choice) both using 2013/14 Hospital Episode Statistics. It includes payment for admitted patient care, outpatient procedures and outpatient attendances. Together, these are around 85% of nationally-priced spending. It excludes maternity services due to data limitations. It also excludes patients whose equalities characteristics are unknown.

[33] This is due to technical limitations, which we plan to address for future impact assessment work.

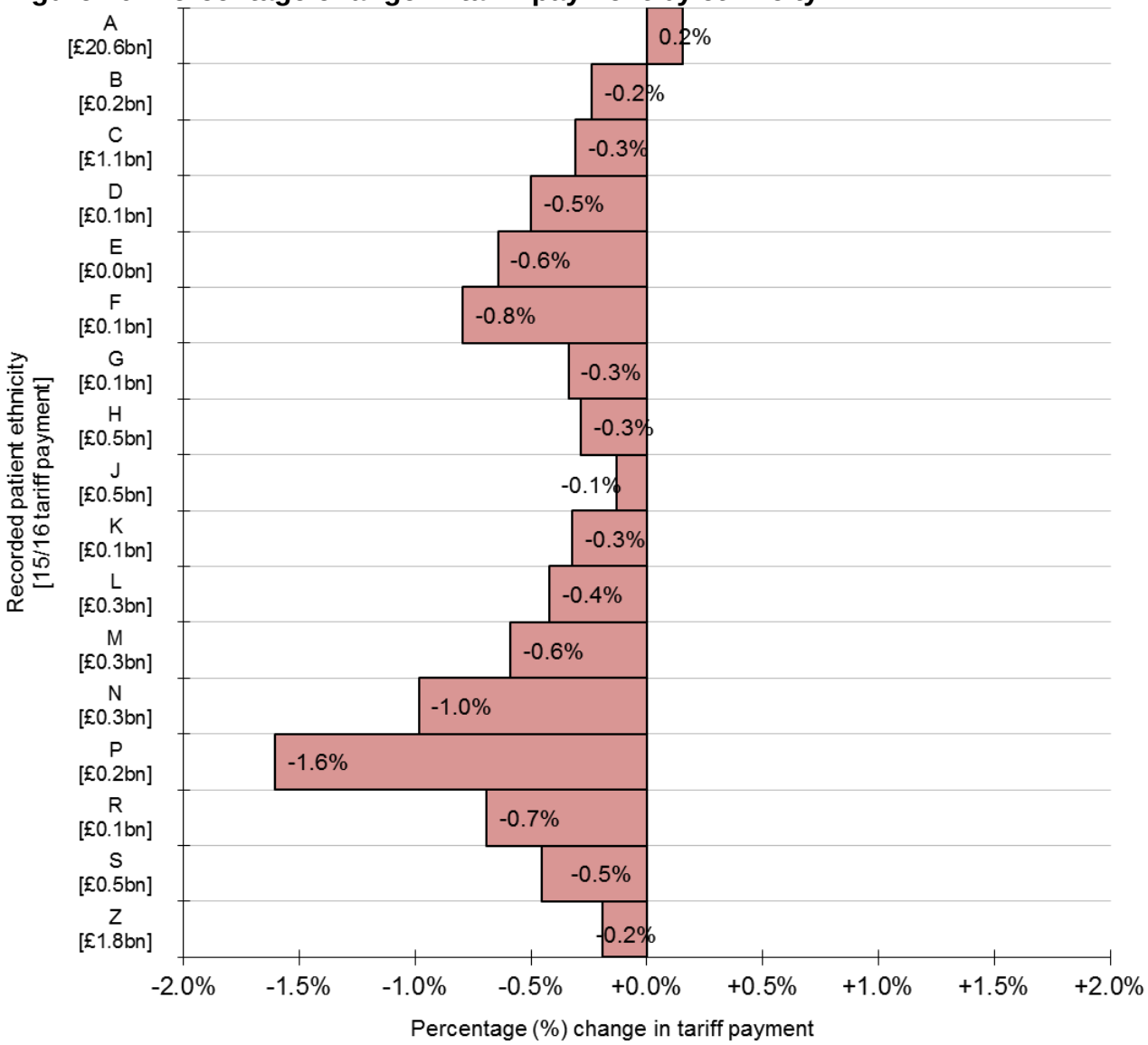
Race (including ethnic or national origins, colour or nationality)

The NTPS does not distinguish between procedures for patients of different ethnic backgrounds. However, some currencies are more likely to apply to patients of certain ethnicities because the prevalence of some conditions varies by ethnicity.

We estimate that, if total activity and spending remained constant, the proposed prices would change nationally-priced spending on all racial groups by between -1.6% and +0.2%. **Figure 10** illustrates average price changes for different ethnic groups.

The price changes in each chapter affect members of different ethnic groups differently. For instance, chapter V (Multiple Trauma, Emergency Medicine and Rehabilitation) sees an increase in revenue to all ethnic groups.

Figure 10: Percentage change in tariff payment by ethnicity



Notes:

Ethnicity Codes: A = British (White); B = Irish (White); C = Any other White background; D = White and Black Caribbean (Mixed); E = White and Black African (Mixed); F = White and Asian (Mixed); G = Any other Mixed background; H = Indian (Asian or Asian British); J = Pakistani (Asian or Asian British); K = Bangladeshi (Asian or Asian British); L = Any other Asian background; M = Caribbean (Black or Black British); N = African (Black or Black British); P = Any other Black background; R = Chinese (other ethnic group); S = Any other ethnic group.

Source: Monitor analysis

We expect the removal of the specialised services risk share to have a positive impact on this protected characteristic, as providers on the ETO will now be fully reimbursed for specialist services. Some specialist services may be more likely to

apply to patients of a particular ethnicity where some health-related issues are more prevalent. [34] This will have no impact on patients of providers on the DTR.

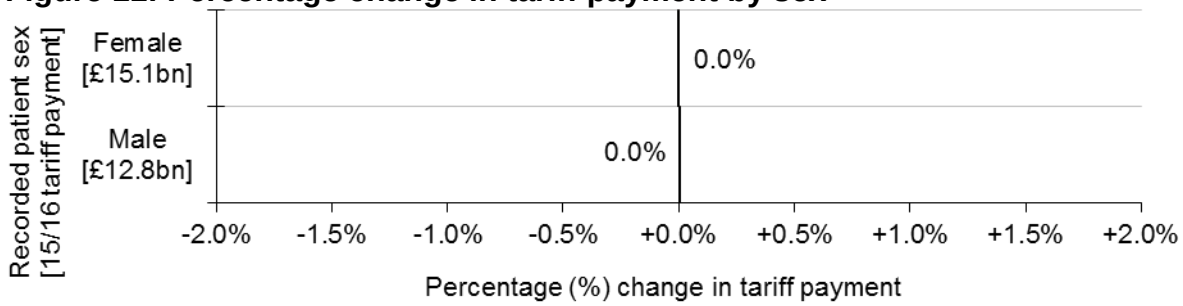
We have not identified any other aspects of the proposals which we expect to have a material disproportionate impact on any particular racial group.

Sex

Certain procedures are, by their nature, specific to male and female patients. For some HRGs, the procedures specify the exclusive sex in their descriptions. There are also HRG chapters dedicated to sex-specific procedures.

However we estimate that, assuming activity and spending remain constant, the proposed prices would affect nationally-priced spending on men and women in very similar ways. **Figure 11** shows that total spending on patients recorded as both male and female would change by around 0%.

Figure 11: Percentage change in tariff payment by sex



Source: Monitor analysis

BPTs for operations to manage female incontinence (day case BPT) and diagnostic hysteroscopy (outpatient BPT) are part of the ETO, and also form part of our proposals for 2016/17. They are not part of the DTR. Female patients of providers moving from DTR are likely to be positively affected by the introduction of these BPTs, with more of them being treated in a day case setting. This should also lead to a decline in the waiting time for these procedures.

We have not identified any other aspects of the proposals which we expect to have a material disproportionate impact on any sex.

Disability

Many HRGs in the HRG4 design differentiate between care provided for a patient with or without complications and comorbidities in order to reflect the higher

[34] For example, there is research to suggest that people from Black, Asian Black, Asian and Minority Ethnic (BAME) groups have specific health requirements. For example, people of Black Caribbean origin are reported to have high rates of hypertension and a higher probability to contract sickle cell anaemia; all ethnic minority groups are reported to have high rates of diabetes. Some of these are treated within a specialist service setting. See, for example: House of Commons Health Committee. “Health inequalities, third report of session 2008-09, volume 1” 2009

expected resource use of treating patients who do have complications and comorbidities. Comorbidities can be associated with disability. Therefore, the HRG4 design helps ensure that people with disability are treated equally by national prices.

We have not identified any other aspects of the proposals which we expect to have a material disproportionate impact on any particular group of people with disabilities.

Pregnancy and Maternity

The proposals include changes to the maternity pathway, involving the use of additional clinical factors to help better assign the correct level of complexity to the antenatal phase. These aspects of the maternity pathway form part of our proposals for 2016/17. Maternity patients of providers currently on the DTR are therefore likely to benefit from our proposals, as they will help ensure that they are assigned to the correct pathway according to clinical need.

We have not identified any other aspects of the proposals which we expect to have a material disproportionate impact on any group with a particular pregnancy or maternity status.

Gender Reassignment

The removal of the specialised services risk share may have a positive impact on patients of gender reassignment services. This is because gender reassignment is a specialised service, and therefore the removal of the risk share means ETO providers will now be paid the full price for providing such services.

We have not identified any other aspects of the proposals which we expect to have a material disproportionate impact on any group with a particular gender reassignment status.

Marriage and civil partnership

The NTPS does not distinguish between procedures for patients with different marital or civil partnership status.

We have not identified any aspects of the proposals that are expected to have a material disproportionate impact on any group with a particular marriage or civil partnership status.

Sexual Orientation

The NTPS does not distinguish between services for patients based on their sexual orientation.

We have not identified any aspects of the proposals that are expected to have a material disproportionate impact on any group with a particular sexual orientation.

Religion or belief (including lack of belief)

The national tariff does not distinguish between services based on the religion or belief of the patients in question.

We have not identified any aspects of the proposals that are expected to have a material disproportionate impact on any group with a particular religion or belief.

8. Patient choice and competition

Monitor's role as sector regulator includes ensuring that procurement, choice and competition operate in the best interests of patients and preventing anti-competitive behaviour in the provision of healthcare services that is not in patients' interests.

This impact assessment considers whether the 2016/17 NTPS proposals are likely to affect competition in a way that may be detrimental to patients.

8.1. Approach to assessment

The Health and Social Care Act 2012 requires Monitor to conduct an assessment of the likely impacts of the pricing proposals, but does not specify the form of the assessment. Monitor has assessed the potential effects against the competition checklist criteria set out in the Competition and Markets Authority (CMA) Guidelines to help government policymakers assess the impact their proposals will have on competition.[35] The assessment therefore considered whether the proposals are likely to:

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

The assessment also considered whether the proposals are likely to facilitate anti-competitive behaviour given Monitor's role in preventing such behaviour.

Monitor has undertaken a qualitative assessment of the potential impacts on patient choice and competition. A complete assessment of all likely effects on competition would require a detailed analysis of around 2,000 product markets across the whole NHS sector. This, however, would not be proportionate or feasible, given the timescales for the publication of the 2016/17 NTPS and the wider regulatory framework for competition and pricing.

Two principles of Monitor's duties guide this impact assessment:

- **the role of national prices in facilitating patient choice and competition between providers**: The 2016/17 NTPS payment regime regulates prices for the majority of acute healthcare, and hospitals are remunerated according to the number of procedures they carry out. As national prices are fixed, providers cannot compete on price so they compete for patient referrals by

[35] See CMA 'Competition Impact Assessment' (CMA50), Part 1 (overview) and Part 2 (guidelines), 15 September 2015 at https://www.gov.uk/government/publications/competition-impact-assessment-guidelines-for-policymakers.

increasing the quality of the services they provide. In this way, providers have a financial incentive to make long-term investments and improve the quality and efficiency of their services to attract more patients and consequently more revenues.

- **that regulated national prices should reflect providers' efficient costs of delivering the relevant services.** How prices are set and the level at which they are set when compared with the costs of provision are likely to have significant effects on incentives of providers and commissioners and therefore market structure and competition. While pricing below some providers' costs could give those providers an incentive to provide services efficiently, prices set substantially below providers' costs may challenge providers' financial position and sustainability of services. This may result in exits from the market and could constitute a deterrent for new entry, reducing patients' choice.

8.2. The assessment

This subsection comprises the assessment of the impact on patient choice and competition of the following proposals, being those proposed changes to the NTPS that Monitor considered to have potential implications for choice and competition:

- Changes in relative prices
- Changes in the overall level of prices
- The marginal rate emergency rule
- Specialist services marginal rate removal

The changes are assessed against the competition checklist set out in section 1.1. Any potentially significant effects highlighted by the qualitative assessment are discussed in the sections below.

8.2.1. Changes in relative prices

NHSE and Monitor propose to base national prices on those included in the ETO, uplifted to the 2016/17 financial year. Relative prices of providers who currently operate under the ETO (88% of providers) are therefore not affected by this change.

Monitor expects that the proposed change would affect relative prices of services for providers currently operating under the DTR. The changes in relative prices may affect the incentives of providers who are currently under the DTR to compete in respect of certain services, as relative margins change and providers' ability to cross-subsidise between different services therefore also changes. This could have impacts on the range of suppliers or the intensity of competition. However, efficient providers will be able to provide services given that national prices are intended to reflect the efficient costs of provision. Monitor therefore does not consider that this proposal creates any significant risks to patient choice and competition in terms of directly limiting the number or range of suppliers or limiting their ability to compete.

8.2.2. Changes in the overall level of prices

As described in Section 2 of this report, NHS England and Monitor propose to set the efficiency factor at 2% and the inflation uplift at 3.1%, as well as making average CNST adjustments to prices of 0.7%. Overall the net effect of these adjustments would be to increase the average level of prices by 1.9% of total revenue for ETO providers and 0.5% of total revenue for DTR providers (excluding any impact from the reintroduction of CQUIN). This would differ from previous years when prices decreased on average as the efficiency factor was higher than the combined inflation and CNST uplifts. If the current ETO/DTR arrangements continued, price levels would remain the same, but provider costs would increase by 3.8% on average, which would mean provider margins would fall. The effect of the proposed changes to price levels would therefore be, on average, an increase in margins across all service lines, compared with the current ETO/DTR arrangements continuing.

As providers are, on average, expected to earn higher margins than they would have if the current arrangements continued, we do not expect the change to lead, directly or indirectly, to the exit of any providers. Therefore, we do not expect the change to negatively impact the number of providers, their ability to compete or the choice and information available to patients.

Higher margins may incentivise providers to compete for patients more vigorously than if the current arrangements continued as additional activity would, on average, attract a higher margin. As providers compete on quality, this may lead to providers offering patients a higher quality of service.

Overall, we expect the proposed price changes may have a positive impact on competition compared with the current arrangements continuing.

8.2.3. The marginal rate for emergency admissions

The marginal rate rule was introduced in 2010/11 in response to concerns about growth in the volume of patients being admitted to hospital as emergencies. The rule sets a baseline value for income from emergency admissions for each provider. For emergency admissions above this baseline, the provider receives a set percentage of the normal price.[36] The rule is intended to give acute providers an incentive to collaborate with other parties in the local health economy to manage demand for avoidable emergency admissions and to treat patients in the most appropriate setting.

For 2015/16, the marginal rate of 70% was applied to those providers who opted for the ETO (88%). For the rest of the providers who opted for the DTR the marginal rate was 30%. NHSE and Monitor propose to increase the marginal rate to 70% for

[36] See Monitor and NHS England's review of the marginal rate rule for a more detailed description of the marginal rate rule

all providers to align the incentives better between providers and commissioners to manage growth in emergency admissions. This change will only affect the 13% of providers who are currently being paid a 30% marginal rate, and will mean that they will be reimbursed at a higher rate for their marginal emergency admissions.

Monitor considered the potential effect of the change on the number or the competitive incentives of providers. Monitor's view is that the change is unlikely to lead to a reduction in the number of A&E departments as the change means an increase in the reimbursement for marginal emergency admissions for the providers affected by the change. The higher margins, compared to the current situation, may also encourage providers to compete more vigorously for A&E patients by improving the quality of their A&E departments. Therefore, overall, the change is unlikely to adversely affect the number of providers or their competitive incentives.

8.2.4. Specialised services marginal rate rule

For those providers currently operating under the ETO, NHS England and Monitor are proposing to remove the specialised services marginal rate rule. This rule states that above a given volume-based threshold of activity, prices for certain specialised services are reduced to 70% of the national price. Consequently, if the rule was removed, prices for all activity would be at the national price regardless of the volume of activity.

The increase in prices for certain activity when compared with keeping the rule in place has the potential to increase margins, and therefore drive competition in two ways. Firstly, it may encourage providers to compete more vigorously to become specialised service providers. Secondly, incumbent specialised service providers may have a stronger incentive to compete for additional activity compared to the current situation in which that activity was paid at the lower marginal rate. Monitor's view is that the change is not likely to have a negative impact on the number of providers or the competitive incentives of providers.

Annex 1: Enhanced impact assessment

1.1. Background

The National Tariff Payment System (NTPS) is complex. It involves more than 2,000 prices, as well as an array of rules and incentives designed to influence how providers and commissioners of NHS-funded care behave. Because of this complexity, there is always more that can be done to better understand the tariff's impact.

As well as being a statutory requirement, our impact assessment is a high priority for us, because of the influence it has on development of proposals for the NTPS. Monitor and NHS England decisions about the policies to include in the statutory consultation notice have been informed by impact assessment. We also expect that the impact assessment will influence whether providers and commissioners choose to accept or reject our proposed method for setting national prices. It is therefore important that our impact assessment is as comprehensive and accurate as possible.

Each year we seek to develop our impact assessment (IA) approach. This year, for example, we have sought to do more to identify the types of patient who are most affected by our NTPS policies, and why. In addition, we have done more to assess the combined impact of the NTPS proposals.

Feedback from providers and commissioners can help us further develop and quality assure our IA. Each organisation has local knowledge about how the tariff affects them that we do not have access to. It is also useful to expose our calculations and assumptions to external scrutiny.

Providers and commissioners also want to provide feedback. In response to the engagement documents we published over the last eighteen months, a number of organisations said they would value the introduction of something like the 'sense check' process run by the Department of Health, where each year a small number of providers were given advance sight of proposed national prices, and asked to give feedback on the Department's IA of them. We have also been approached by a number of organisations with questions and comments about our IA work.

We have therefore run a project, the 'enhanced impact assessment', designed to improve our IA work by taking account of feedback from providers and commissioners. Through this project, we hoped to discover both immediate improvements we could make to our IA, and areas we could consider for developing the IA in future. We ran this project in collaboration with NHS England.

Earlier this year, we published an engagement document about our proposals on currency design and relative prices.[37] Alongside this, we published our preliminary IA of these proposals.[38] Part of the preliminary IA compared provider revenue from 2015/16 prices (either Enhanced Tariff Option (ETO) or default tariff rollover (DTR), depending on the provider's choice) with revenue from our proposed 2016/17 relative prices (draft prices).

The enhanced impact assessment gathered feedback on the preliminary IA from a representative group of providers, working with their commissioners. While the enhanced impact assessment is similar to the Department of Health's 'sense check' in many ways, it takes a different approach in some areas. For example, we ran this project alongside wider sector engagement on proposed -national prices, so that all providers and commissioners have access to information on proposed national prices at the same time. We also tried to increase the range of providers taking part.

We selected participants by issuing a call for volunteer providers, in co-operation with NHS Providers, NHS Clinical Commissioners and the NHS Confederation. We received twenty-nine volunteers, and selected from them a group of fourteen providers designed to include a mix of provider types and sizes, and coverage of a range of different types of care. One participant withdrew early. The remainder are listed below.

Figure A.1.1: Enhanced impact assessment participants

Bolton NHS Foundation Trust
Central Manchester University Hospitals NHS Foundation Trust
Great Ormond Street Hospital for Children NHS Foundation Trust
Guy's and St Thomas' NHS Foundation Trust
Nottingham University Hospitals NHS Trust
Royal Brompton & Harefield NHS Foundation Trust
Royal National Orthopaedic Hospital NHS Trust
Sheffield Teaching Hospitals NHS Foundation Trust
Shrewsbury and Telford NHS Trust
Spire Healthcare
Taunton and Somerset NHS Foundation Trust
University College London Hospitals NHS Foundation Trust
University Hospitals Bristol NHS Foundation Trust

Source: Monitor

[37] Monitor and NHS England (2015), *2016/17 national tariff proposals: Currency design and relative prices*

[38] Monitor (2015), *Impact Assessment of 2016/17 national tariff proposals: Currency design and relative prices*

We shared with each participant our assessment of the impact **on them** of some of our proposals, and asked them to compare this with their own assessment. We shared with all participants our IA of the draft prices for admitted patient care, outpatient care and A&E prices. We also shared with a sample of participants our IA of draft prices for unbundled and maternity services.[39] Four participants are also members of the Specialised and Complex Care Working Group that we worked with as we developed our policy on top-up payments for specialised services. We shared with these participants our IA of some preliminary proposals for top-ups. We also shared with them our IA of changes to education and training funding. While education and training funding is not part of the NTPS, it is an input into our financial model of NHS providers and is therefore relevant to our IA.

1.2. Initial comparison

Two factors can cause differences between Monitor and provider IA: differences in the year of activity data used and other differences in calculation methodology. We assess the impact of price changes on a provider by applying both the provider's 2015/16 prices (ETO or DTR) and our draft prices to the provider's nationally-priced activity for a given financial year. This allows us to calculate what the provider's total nationally-priced revenue would be with both 2015/16 prices and draft prices. Providers could produce a different estimate of the change in nationally-priced revenue if they assume a different year of activity, or if their method differs in other ways. Methodology differences could include the source of activity data used, or the method for applying prices to activity.

To help us identify whether there were methodology differences, we asked providers to conduct their IA using the same year of activity data as us. We generally assume 2013/14 activity, as this is the most recent activity data available nationally.[40]

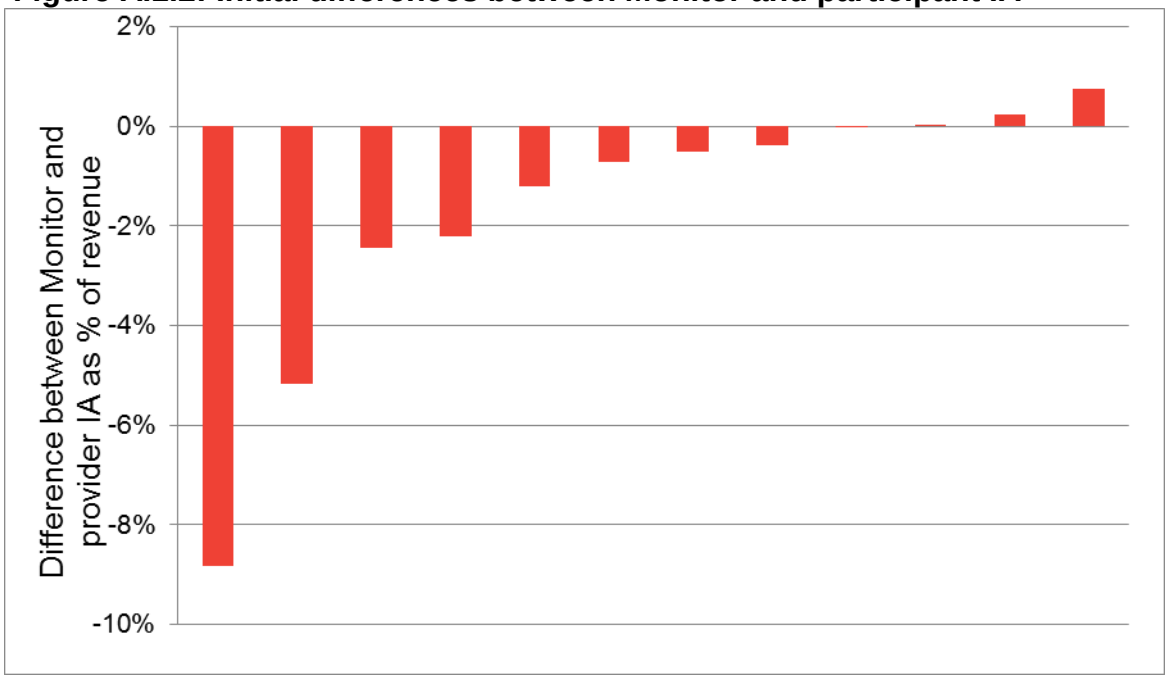
Our assessment of impact differed from participants' by £37 million (1.3% of the revenue in the scope of this exercise) overall. We initially estimated that the policies assessed would reduce the provider revenue in the scope of this exercise by £43 million, from £2,925 million to £2,882 million. Participants however estimated that the policies would reduce their revenue by £80 million, from £2,939 million to £2,858 million.[41]

Within this, there was variation in how closely Monitor's IA aligned with providers'. For one provider, the assessment differed by less than 0.1% of revenue. At the other

[39] Unbundled currencies cover a small number of services that have been split off (unbundled) from a currency covering a whole pathway of care, to enable different parts of the pathway to be provided by different providers. At present, unbundled currencies cover some types of scan, as well as chemotherapy and radiotherapy.
[40] We use 2013/14 Hospital Episode Statistics.
[41] Some providers also sent us their IA of policy changes outside the scope of the enhanced impact assessment exercise. That IA is not included in these figures.

extreme, for another provider the assessments differed by around 9% of revenue. **Figure A.1.2** shows the distribution of these differences.

Figure A.1.2: Initial differences between Monitor and participant IA



Source: Monitor

We found that for most providers the difference between the Monitor and provider IA was driven by a small number of specialties (which differed from provider to provider). With the effect of these specialties removed, the remaining differences between Monitor and provider IAs were not material.

We therefore worked with each participant to investigate the specialties where the Monitor and participant IA differed the most. We were particularly interested in whether the differences indicated areas where we should develop our assessment approach. The next two sections describe what we found.

1.3. Findings that have changed our impact assessment approach

Finding 1: Our preliminary IA was biased by how it treated activity newly in the scope of national prices

What we found: Our preliminary IA estimated the impact of price changes on providers by comparing revenue from 2015/16 national prices and draft prices. However, a small number of HRGs in the draft prices relate to activity that is not nationally-priced in 2015/16. Therefore, our assessment was not fully comparing like with like. Our estimate of draft prices revenue included revenue relating to new-in-scope activity, while our estimate of 2015/16 price revenue did not include the current locally-priced revenue for this activity. This made the revenue impact of the proposed price changes appear more positive.

What we did: In principle, the best way to assess the impact of bringing activity into the scope of national prices is to compare the proposed national price for that activity with the local price. Unfortunately, we do not currently hold data on most local prices.

As a first step, we removed activity that is not in the scope of all three sets of prices (DTR, ETO and proposed 2016/17 prices) from our IA. This means that our IA is comparing revenue from the three different sets of prices on the basis of the same activity. In the main body of this report we separately discuss what we know about changes to the scope of prices.

In future, we are considering gathering data on local prices for new-in-scope activity from providers and commissioners as part of our engagement on national prices.

Finding 2: Our preliminary IA was biased by how it treated drugs and devices newly in the scope of national prices

What we found: Mostly, the national price for a treatment is meant to include the cost of any drugs or devices used during the treatment. However, this is not the case for items on the high cost drugs and devices lists. National prices exclude the cost of items on these lists, and where they are used, payment for them is agreed between providers and commissioners locally. We are proposing for 2016/17 to move some items off these lists and into the scope of national prices.

Our preliminary IA was biased by how it treated the inclusion of these items in national prices, in a similar way to **Finding 1**. Draft prices affected by this change now cover both the cost of the item and the other costs of the procedure. Comparing these draft prices with 2015/16 prices (which only cover the other costs of the procedure) was not comparing like with like. This again made the revenue impact of the proposed price changes appear more positive.

What we did: To assess the impact of bringing items off the drugs and devices lists, we would need to know the local prices providers receive for these items. Unfortunately, we do not hold this data.

We have therefore removed activity whose price is substantially affected by proposed changes to the high cost drugs and devices lists from our IA. In the main body of this report we also separately discuss what we know about changes to the drugs and devices lists.

In future, we are considering gathering data on local prices for items we are proposing to remove from the drugs and devices lists as part of our engagement on national prices.

Finding 3: Because of the way it applied the market forces factor, it is likely our preliminary IA slightly underestimated the impact of policy proposals on independent providers

What we found: The market forces factor (MFF) is an index of unavoidable cost differences between providers. These might arise from, for example, geographical differences in staff wages or the cost of buildings. It is used locally to adjust nationally-priced payments. This means that, for example, providers in London receive higher prices than providers in Cornwall, to allow for the higher costs of operating in London. In the ETO, the MFF ranged from 1.00 (Royal Cornwall Hospitals NHS Trust) to 1.30 (University College London Hospitals NHS Foundation Trust).

In our preliminary IA we applied individually-calculated MFFs to NHS providers, but attributed to all independent providers an MFF of 1. This is because we do not hold data on the MFF of independent providers. We calculate the MFF of NHS providers, but ask independent providers to calculate their own, which should be the MFF of the NHS provider nearest to where the care took place.

This means it is likely our preliminary IA slightly underestimated the impact of our proposals on independent sector providers. Increasing both 2015/16 prices revenue and draft prices revenue by an MFF factor would increase the difference between the two revenue amounts, when measured in £. It would not however have any effect on our estimate of the difference when measured as a percentage of revenue.

What we did: Ideally, we would calculate and apply an MFF for each independent provider. However that would have required additional data collection and analysis, which was not feasible in time for this report.

Instead, we have applied the national average MFF (1.05) to all independent providers. While this is only an approximation of providers' actual MFF, we consider it is likely to be more accurate on average than 1.00 (which is the minimum possible).

In future, we will look to further refine the way we apply the MFF to independent sector providers.

Finding 4: Our model of education and training funding did not contain the most recent information

What we found: Health Education England has recently changed the way providers are paid for education and training. Providers are currently transitioning from their old payment arrangements to the new payment arrangements. Where the new payment arrangements would result in a loss of income, providers are entitled to receive temporary transition payments so that their funding does not change too quickly from year to year.

Our source for these payments was a model produced by the Department of Health. However, we found that this model did not take account of a policy change which had affected the trajectory of transition payments.

What we did: We have now obtained from the Department an update on education and training funding which contains the most recent information on transition payments. With this update, our figures for the change in education and training funding between 2015/16 and 2016/17 now reconcile with participants'.

We also found that some differences were driven by other, smaller issues. For example, our preliminary IA attributed around £10 million of revenue to the subchapter UZ, which relates to activity that is not eligible for payment and should always have a price of zero. We found that this was because in our draft prices we had, in error, given a non-zero price to excess bed days in in subchapter UZ. We have now corrected this.

1.4. Other reasons for differences between Monitor and provider assessments

Finding 5: Sometimes the data providers submit to the Secondary Uses Service does not accurately reflect local payment arrangements, and this affects our IA

Our IA depends on Hospital Episode Statistics (HES) activity data, which is derived from data submitted by providers to the Secondary Uses Service (SUS).[42] If the data providers submit to SUS does not accurately reflect local payment arrangements, this will distort our IA.

We found some cases where participants had submitted data to SUS that did not reflect local payment arrangements. This seems to be caused by a number of different factors. For example, one participant told us that the way they are required to submit data to SUS can make it difficult to accurately reflect local payment arrangements. Another told us that their billing to commissioners is not based on SUS data, and therefore ensuring the accuracy of SUS data is a lower priority than ensuring the accuracy of billing data.

We ask all providers to do everything they can to ensure the data they submit to SUS is as accurate and complete as possible. We are involved with Health and Social Care Information Centre working groups on both the improvement of SUS and its eventual replacement. We will be feeding our findings into those working groups.

Finding 6: Differences between Monitor and provider IA are also driven by a range of other factors

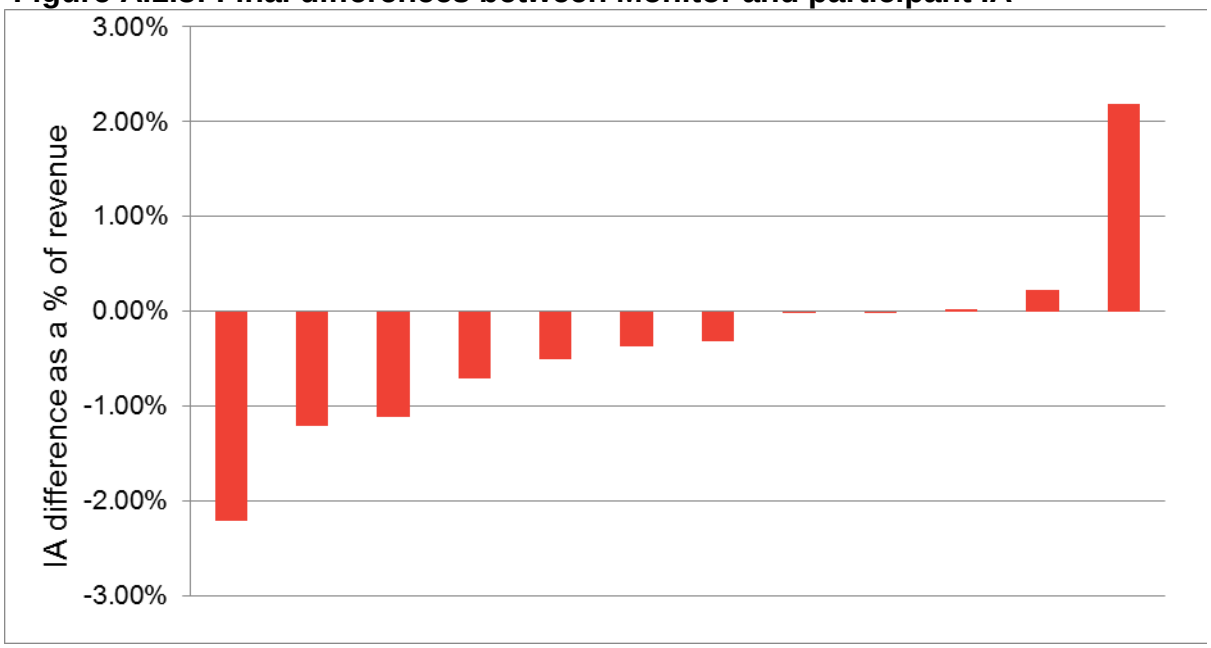
We expect that even if we were able to address Findings 1 to 5 in full, Monitor and provider IA will never reconcile exactly. The work involved is complex and requires multiple analytical judgments, which will inevitably differ from person to person.

[42] The Secondary Uses Service (SUS) is the repository for healthcare data in England. It enables a range of reporting and analyses to support the NHS in the delivery of healthcare services.

We found that, after we had addressed Findings 1 to 4 as described above, our IA now differed from participants' by £12 million (0.4% of the revenue in this exercise) overall. Our revised estimate is that in-scope provider revenue would reduce by £68 million, from £2,931 million to £2,862 million. This is closer to the provider estimate we cite above of an £80 million reduction, from £2,939 million to £2,858 million.

Variation in how closely Monitor's IA aligned with providers' remained after these adjustments, however this range is now smaller. The greatest difference between Monitor and provider IA is 2.2% of revenue, with 0.01% being the smallest**. Figure A.1.3** shows the difference between Monitor and participant IAs post any data adjustments.[43]

Figure A.1.3: Final differences between Monitor and participant IA



Source: Monitor

Part of the remaining difference between Monitor and provider IA was due to the choice of activity data. Some providers calculated admitted patient care activity using Finished Consultant Episodes, rather than spells. We consider that spells are a more appropriate basis for IA calculations, as this is what NTPS payments should be based on.

We also found that we had treated best practice tariffs (BPTs) differently to providers. With BPTs, providers receive a different price depending on whether or not the care they provide meets certain criteria for best practice. We excluded BPTs from our preliminary IA, by applying standard prices (ie the prices that would have applied if there had been no BPT) to all activity. However, we found that a number of

[43] One participant submitted a relatively limited amount of data. We have excluded that participant from this figure.

providers had included some best practice prices in their IA. This seems to be due to a number of practical factors (such as the way SUS treats BPTs) which made it challenging for providers to fully exclude BPTs from their analysis. We will bear these challenges in mind if we conduct the enhanced impact assessment again next year; it may make sense for us include BPTs in the exercise.

Also, some differences between us and providers seem to be due to differences in the selection of which activity to exclude from IA calculations. For the majority of participants the differences affect a small number of areas. However, for one provider they affect a wide range of areas. We are continuing to work with this provider to understand the reasons for these differences.

It is important to note that we ran this exercise on the basis of the draft prices we published alongside our summer engagement document, and therefore the results would be different if we ran it again with a different set of prices.

1.5. Outcome

We started the enhanced impact assessment with two aims, both of which we think have been achieved. We set out to find immediate improvements we could make to our IA, and areas where we could develop our IA in future.

The IA presented in the main body of this report has been upgraded to take account of the findings of the enhanced impact assessment. It includes the improvements we describe above in relation to Findings 1 to 3. While we have not implemented analytical improvements relating to Findings 5 and 6, we have caveated our work appropriately. Finding 4 is not relevant to the analysis presented in this report, because it does not relate to NTPS revenue.

We are considering further work in relation to our findings over the coming months. In particular, Findings 1 and 2 may be best addressed by gathering data from providers as part of our engagement on national prices. We hope to work with participants on how best to do this.

This process has also reinforced for us the importance of explaining, and if necessary mitigating, the effects of currency, cost and policy changes.

We would like to thank all participants for their involvement. We have found this project very valuable, and we hugely appreciate the time and effort which everyone has put in.

Annex 2: Monitor's statutory duties

Under Section 69(5) of the 2012 Act, Monitor's impact assessment must include an explanation of how the discharge of Monitor's duties under Sections 62 and 66 would be secured by implementation of NHS England and Monitor's proposals.[44] 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 Monitor has complied with the duty in developing and making these proposals.

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

Monitor'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.

Section 62 of the 2012 Act

Section 62(1): protect and promote the interests of patients[45]

Consideration of the interests of patients is fundamental to the proposals in the consultation notice. For example, as set out in Section 4 of Part B of the consultation notice, NHS England and Monitor's aim in setting prices is to support the highest quality care within the existing healthcare budget.

This duty requires Monitor to protect and promote the interests of patients by promoting "*provision of health care services which – a. is economic, efficient and effective, and b. maintains or improves the quality of the services.*" How our proposals would discharge that duty is explained in more detail below, by reference to each limb of the duty.

[44] 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. Those instruments do not allow for NHS England and Monitor to develop a comprehensive payment system including, for example, (i) a method for setting national prices for specific currencies in a way that promotes effective and economic provision of services and (ii) a framework for local pricing that takes account of the duties of commissioners which are in particular to ensure fair access to services using a limited budget and make best use of resources in doing so.

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

Section 62(1)(a): economic, efficient and effective provision of health care services

Section 7 of Part A of the consultation notice sets out how in setting national prices Monitor and NHS England have followed the principles that prices should reflect efficient costs and provide appropriate signals, while at the same time recognising the financial realities facing the NHS.

Monitor considers that setting prices in a way which balances these factors promotes the economic, efficient and effective provision of healthcare services. Prices which reflect efficient costs and provide appropriate signals should enable commissioners to choose the mix of services that offer most value to the populations they serve, incentivise providers to reduce costs, and encourage providers to change delivery model where this makes sense. At the same time, price stability makes it easier for providers and commissioners to plan and to agree contracts; earlier agreement is likely to make provision of those services more effective.[46]

The economic, efficient and effective provision of health care would in particular be promoted by our proposals for the efficiency and cost uplift factors[47], which take account of the need for efficient deliver of services, while recognising increases in costs. Changes to Best Practice Tariffs and to the maternity pathway[48] are also specific examples of where our proposals are designed to improve effectiveness of care. The framework for locally determined prices and proposals for deadlines for notifications to Monitor has also been designed to promote the economic, efficient and effective provision of healthcare services. In particular, the proposals should facilitate better forward planning for commissioners which in turn increases the likelihood of more efficient outcomes via contract negotiations. We propose to retain the local pricing principle that payment approaches should be in the best interests of patients, which includes consideration of cost effectiveness[49].

Section 62(1)(b): maintaining or improving quality of healthcare services

As set out in Section 4 of Part B of the consultation notice, NHS England and Monitor's aim in setting prices is to support the highest quality patient care within the healthcare budget.[50]

In setting the efficiency factor, NHS England and Monitor have had regard to the potential risks to the quality of care if prices are set too low.[51] This also informs cost uplifts, which ensure that prices are adjusted to reflect costs over which providers have little control.

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[46] See Consultation Notice, Part A Sections 2, 6, 7
[47] See Consultation Notice, Part A Section 7.3 to 7.5 and Part B, Section 4.2 and 4.3.
[48] Consultation notice, Part A, Sections 6.4 and 6.6, and Part B, Section 3.2.7 and 3.2.9.
[49] Consultation notice, Part B, Section 6.1.
[50] Consultation notice, Part A Section 7.1.1 and Part B, Section 4.
[51] Consultation notice, Annex B5.

Monitor also expects that the following proposals forming part of national prices will contribute to quality improvements:

- Retention of, and changes to, a number of best practice tariffs that are intended to improve quality of care
- Manual adjustments to ensure prices are more cost reflective should help to facilitate improvements in care quality in instances where a previous lack of revenue risked care quality

Section 9 of Part A, and Section 6 of Part B, of the consultation notice has set out proposals for locally determined prices. Our proposals for setting deadlines for notification of local variations and local modifications to Monitor should facilitate improvements in care quality by improving forward planning by commissioners and providers of care services. Our proposed clarification of the relevant local payment rules should help ensure payment for mental healthcare is evidence-based and supports good quality care. In addition, we propose to retain the local pricing principle that payment approaches should be in the best interests of patients, which includes considering how a payment approach will maintain or improve quality of care for patients both now and in the future.[52]

Monitor's impact assessment generally has had regard to the risks of adverse impacts on quality of care.[53]

Section 62(2): have regard to likely future demand for health care services

While Monitor and NHS England only intend the 2016/17 NTPS Payment System to be in force for one year, in setting the proposed efficiency assumption and cost uplift factors, Monitor has had regard to the future financial sustainability of providers.

The proposals to change the emergency admissions marginal rate for providers on the DTR from 30 to 70% are also intended to create incentives for providers and commissioners to work together to manage the demand for services.

In addition, the first local pricing principle requires commissioners to consider the best interests of patients both now and in the future.[54]

Section 62(3): competition and co-operation

The competition implications of the proposals are discussed in detail in Section 8 of this report. Overall, we consider that the proposals do not facilitate anti-competitive behaviour which is against the interests of patients.

[52] Consultation notice, Part B, Section 6.1.
[53] For example, Section 2.6.
[54] Consultation notice Part B, Section 6.1.1.

Section 62(4), (5) and (6): integration and co-operation

As detailed in Section 6.2 of Part B of the consultation notice, the proposed rules for varying national prices 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 with national or local currencies, or supporting integration of primary, secondary and social care with payment aligned to outcomes.

In addition, the proposals for the marginal rate rule could strengthen the incentive on commissioners to work together with providers to reduce avoidable emergency admissions, which would be to the ultimate benefit of patients. On the other hand, commissioners are already required to spend the money they retain due to the marginal rate rule on schemes for reducing emergency admissions; making the marginal rate more in favour of providers may reduce the funds commissioners have for such schemes.

Section 62(7): patient and public involvement

Patient representative and condition representative groups were invited to offer feedback as part of the stakeholder engagement process over the summer. This feedback was taken into account as part of Monitor and NHS England's decision-making on the NTPS. The feedback received on each policy, and how it has affected that policy, is discussed in the consultation notice.

Section 62(8): clinical and public health advice

(8) Monitor must obtain advice appropriate for enabling it effectively to discharge its functions from persons who (taken together) have a broad range of professional expertise in-
a. the prevention, diagnosis or treatment of illness (within the meaning of the National Health Service Act 2006), and
b. the protection or improvement of public health.

Monitor and NHS England have engaged extensively with clinical experts during the development of proposals for the 2016/17 NTPS. Steps taken are discussed in Section 4 of Part A of the consultation notice.

Section 62(9): Secretary of State's duty to promote a comprehensive health service

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 the whole 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, eg the national variation to top up payments for specialised services.[55]
- Are specifically designed to support a comprehensive and efficient NHS which provides quality services to patients.

All of the proposals in the consultation notice have been jointly decided with NHS England, which is subject to the duty in section 1(1) of the NHS Act 2006 Act concurrently with the Secretary of State.

Section 62(10): non-discrimination between providers

The proposals apply equally to all providers of NHS healthcare services, whether public or private. Monitor's impact assessment has included NHS foundation trusts and NHS trusts, as well as an assessment of the impact of relative price changes on the independent sector as a whole.

Section 66 of the 2012 Act

Section 66 requires that Monitor 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, Monitor should do so only so far as is consistent with maintaining the safety of patients.

Section 66(1): safety of people who use healthcare services

NHS England and Monitor 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.[56] NHS England and Monitor have also had regard to the risks of prices being set too low, including the potential risks to safety.[57]

In relation to locally determined prices, we propose to retain the requirements for commissioners and providers to apply the principle that local payment approaches must be in the best interests of patients – in particular that they should consider how a local payment approach would maintain or improve safety[58].

[55] Consultation notice, Part A, Section 8.3
[56] Consultation notice, Part A, Section 7.1.1
[57] Consultation notice, Annex B5
[58] Consultation notice, Part B, Sections 6.1.1, 6.2.2 and 6.4.1.

Section 66(2)(a): continuous improvement in quality

NHS England and Monitor have had regard to the risk to continuous improvement in quality of prices being set too low, for example when setting the efficiency factor and cost uplifts.[59] Providers that are inadequately compensated for the services they provide may withdraw these services, compromise on service quality, and/or under-invest in the future delivery of services.[The proposals for best practice tariffs for 2016/17 also support quality improvement.

In relation to locally determined prices, we propose to retain the requirements for commissioners and providers to apply the principle that local payment approaches must be in the best interests of patients – in particular that they should consider how a local payment approach would maintain or improve quality (outcomes, patient experience and safety)[60].

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

Monitor and NHS England's aim in setting prices is to support the highest possible patient care within the healthcare budget. The proposals recognise that commissioners have limited budgets, while also having a duty to secure services for their local population[61].

For example, the proposals for provider efficiency have recognised the need for providers to continue to make efficiency improvements, which helps commissioners to make best use of their limited resources.[62]

The proposals also give commissioners flexibilities which should help them meet their duties. For example:

- The proposals for local modifications have sought to ensure that health care services can be delivered where they are required by commissioners for patients, even if the cost of providing services is higher than the national price.
- The proposals for local variations help to ensure commissioners can make best of use of their resources where necessary by facilitating better forward planning of contract negotiations with providers.

[59] Consultation notice, Annex B5
[60] Consultation notice, Part B, Sections 6.1.1, 6.2.2 and 6.4.1.
[61] For example, Consultation notice, Part B, Section 4
[62] Consultation notice, Annex B5

In Section 3 of this report, Monitor has assessed the budget impact of national price changes for commissioners. Monitor expects that overall commissioner spending will increase under the national price proposals.

Section 66(2)(e): desirability of co-operation to improve quality of services

Under the proposals, constructive engagement between commissioners and providers is a key principle that must be applied when agreeing all locally determined prices.[63]

Section 66(2)(f) and (g): research and training

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. However, NHS England and Monitor are working to fulfil this duty in other areas; for example, by working with the Department of Health to improve the costing of research, education and training undertaken by healthcare providers.

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)

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

Section 116(13) of the 2012 Act

Section 116(3) requires that when exercising its pricing functions Monitor must have regard to the objectives and requirements in the government's mandate to NHS England.[64] Monitor has had regard to the mandate as the proposals were formulated, and a number of the proposals in the consultation notice support Mandate objectives. For example, Objective 2 of the Mandate is *"To help create the safest, highest quality health and care service"*, and we have outlined above how the proposals in the consultation notice help to maintain or improve the quality of healthcare services. Objective 3 is *"To balance the NHS budget and improve efficiency and productivity"*, and we have outlined above how the proposals contribute to the economic, efficient and effective provision of healthcare services.

Section 119 of the 2012 Act

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

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

Section 119(1) requires Monitor and NHS England to have regard to the different costs incurred by providers who treat different types of patients and differences in

[63] Consultation notice, Part B, Section 6.1.3
[64] Department of Health 2016, *The Government's mandate to NHS England for 2016-17*

the range of healthcare services offered by providers. This is for the purpose of ensuring providers receive a fair level of reimbursement. The effect of this duty is to require Monitor and NHS England to make provisions for adjustments in prices to take account of variations in clinical complexity.

In relation to national prices, this would be achieved primarily by the proposals for national variations, in particular the provision for top-up payments for specialised services.

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. In particular:

- Local variations allow for nationally specified currencies or prices to be amended to reflect significant differences in casemix compared with the national average.[65]
- Local modifications help to ensure that healthcare services can be delivered safely where they are required by commissioners for patients, even if the cost of providing services is higher than the national price.

Section 119(2), (3) and (4): standardisation of currencies

As described in Section 6 of the consultation notice, a system of national currencies is one of the building blocks of the payment system for NHS care.

For 2016/17, NHS England and Monitor propose that national prices are largely based on the HRG4 reference cost design used for the ETO. This incorporates refinements to the design to better reflect clinical practice in national prices when compared with the 2014/15 currency design, resulting in approximately 200 new or changed HRGs that have a national price. This policy reflects continued development of standard currency units to promote efficient and economic levels of pay to providers of NHS-funded care.

[65] Consultation notice, Part B, Section 6.2

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