Monitor
Making the health sector work for patients

Impact assessment of proposals for the *2014/15 National Tariff Payment System*

7 October 2013

Contents

Executive summary

NHS England and Monitor have taken on responsibility for the NHS payment system from the Department of Health (DH) under the provisions of the Health and Social Care Act 2012 (the 2012 Act). In light of this, we recently published proposed changes for the payment system in 2014/15, which are presented in the *2014/15 National Tariff Payment System: A Consultation Notice* (which we refer to as the 'consultation notice').

Under the 2012 Act, we are also obliged to assess the expected impact of the proposals. This document therefore sets out Monitor's impact assessment of the joint proposals in the consultation notice, compared to the counterfactual that the 2013/14 national tariff continues to have effect. It is the first such assessment prepared by Monitor for the national tariff. The structure of this document is intended to be broadly consistent with the consultation notice.

National currencies and prices

The main focus of our quantitative analysis was on the expected impact of NHS England and Monitor's proposals on the change to the level of prices in 2014/15. We found that for commissioners, nominal prices will marginally decrease. Therefore, all else being equal, commissioners will have more room to accommodate increased demand in their local health economies, which may arise in the form of higher volumes, more complex care needs, higher quality expectations, or through a combination of these pressures. We believe that the proposals will therefore be beneficial to patients overall.

For providers, we examined a range of financial metrics under two main scenarios: one in which providers achieve an annual efficiency gain of 4% which, as we set out in the consultation notice, we believe is a reasonable requirement; and one in which providers achieve a lower annual efficiency gain of only 3%. On balance, and with particular consideration to providers' cash positions, our analysis suggested that the majority of providers would remain financially viable under both scenarios (although a number of providers may move from a small surplus to a small deficit if they were to achieve lower efficiency gains of 3%). We also examined a scenario in which providers achieved efficiency gains of 4.5%. Under this scenario we found (not unexpectedly) that provider surpluses increased.

This analysis reassures us that 4% is a reasonable, if stretching, efficiency requirement for the 2014/15 national tariff. It balances the need for providers to remain stable, whilst allowing commissioners to meet rising demand for more and higher quality health care services.

National variations

Another significant change set out in the consultation notice was in relation to the marginal rate rule for emergency admissions. We assessed the impact of the proposals qualitatively. We concluded that our proposals to put in place a stronger framework for setting baselines (a key parameter of the rule) will ensure provider revenues are appropriately increased to take account of increases in emergency admissions that are outside their control. This is likely to benefit providers that have faced significant increases in emergency admissions.

Another change, to ensure better planning to control the demand for emergency admissions, is the introduction of a new requirement for commissioners to co-ordinate the reinvestment of savings from the application of the marginal rate rule. Because the plans should lead to less emergency admissions in the long-term, we believe they should be beneficial for two key reasons. First, it should allow patients to be treated in more appropriate care settings. Second, it should reduce expenditure on treatment in more costly emergency care settings. This will allow commissioner resources to be targeted elsewhere, thereby enhancing overall care for patients.

Locally determined prices

We have also assessed the impact of NHS England and Monitor's proposals for locally determined prices, which introduce changes that are intended to enhance the transparency of local contracting between commissioners and providers. In our impact assessment, we considered that these measures are likely to result in a small increase in administration costs. However, we have sought to reduce this burden by providing standard templates to facilitate data submission and believe that the additional administrative cost is proportionate given the benefits of collating this information centrally. Central collection of local prices (for services with national currencies) will allow Monitor to compare prices for the same services across different providers and could inform our future price setting.

Another change that we have examined relates to our policies for local modifications (which we are required to introduce under the 2012 Act). We have chosen to introduce restrictions on the circumstances in which providers, who have been unable to agree a local modification with their commissioner, can apply to Monitor for a determination. Our assessment shows that these restrictions will limit pressure on commissioner budgets. Moreover, it will allow Monitor to focus our resources on cases where the refusal of commissioners to agree a local modification is most likely to pose a risk to patients.

Specific tests

Based on advice published by the Department for Business Innovation and Skills (BIS), we have considered a range of potential impacts which are of particular relevance to regulatory policy. The BIS guidelines list specific tests, covering a broad range of economic, social, environmental and sustainability impacts. We considered that it was proportionate to analyse four specific tests on competition, rural proofing, small firms and equality.

We considered the impact of the proposals on competition from a qualitative perspective. Overall, our view is that the impact on competition will be beneficial. We believe that downward pressure on prices will encourage greater competition overall as providers seek to offset the reduction in revenue implied by the national tariff decrease by attempting to attract greater volumes of patients by improving the quality of the services they provide. In addition, the new rules to increase transparency in locally determined prices relative to current arrangements may, at the margin, enhance competition by impacting both commissioner and provider behaviours.

Our analysis of rural proofing shows that the 19 providers we have classified as rural or coastal are not impacted disproportionately (when compared to NHS trusts and foundation trusts in general) by NHS England and Monitor's proposals for the *2014/15 National Tariff Payment System*. On the basis of this analysis, we do not believe that rural or coastal providers, and by extension patients, are adversely impacted by the proposed changes.

Our assessment of the impacts of the proposed changes on small providers suggests that there is no material difference compared to larger providers. We therefore conclude that the proposed changes do not discriminate against smaller providers as defined in this impact assessment.

We have considered the impact of the proposed changes to the national tariff on people sharing certain 'protected characteristics'. In doing so, we had regard to the impact assessment of the Health and Social Care Bill and the impact assessment of the PbR national tariff for 2012/13. In summary, we found that the proposed changes were unlikely to affect adversely any of the groups we considered.

1 Introduction

This impact assessment accompanies NHS England and Monitor's proposals in the *2014/15 National Tariff Payment System: A Consultation Notice* (which we refer to throughout this document as the 'consultation notice'). It is the first full impact assessment that Monitor has produced for a national tariff, and sets out our analysis of the expected impacts of the proposed changes for commissioners, providers and, most importantly, patients.

Impact assessments are an important part of the policy development cycle: they enable us to assess policies and proposals, and to test whether they are likely to achieve NHS England and Monitor's objectives. Publishing impact assessments also helps stakeholders to understand and plan for the changes which are being proposed. The intent of this document is to promote transparency around the impacts of the proposed changes to the national tariff, and to provide as much useful information for our stakeholders as possible. Despite the technical content of much of this document, we have sought to focus on the key findings.

This impact assessment is required by section 69 of the 2012 Act. The consultation period for the proposals which are the subject of this impact assessment runs to 4 November 2013.

In this section, we summarise our statutory duties in relation to the impact assessment and explain the structure of this document.

1.1 Statutory duties in relation to impact assessment

Monitor's statutory duties in relation to impact assessment are set out in sections 62 and 69 of the 2012 Act, and Section 149 of the Equality Act 2010.

Section 62 of the 2012 Act states it is Monitor's primary duty to "protect and promote the interests of the people who use health care services". As a result, we consider the impact on patients to be our primary concern for impact assessments.

Section 69 of the 2012 Act requires us to carry out an impact assessment for any proposals we make that are likely to:

- have a significant impact on people who provide health care services for the purposes of the NHS;

- have a significant impact on people who use health care services provided for the purposes of the NHS;
- have a significant impact on the general public in England (or in a particular part of England);
- involve a major change in the activities Monitor carries on; and
- involve a major change in the standard conditions of licences under Chapter 3 of the 2012 Act (section 94).

Further to the requirements of the 2012 Act, the Equality Act 2010 (section 149) requires Monitor to have due regard to the need to prevent discrimination and advance equality of opportunity for groups with protected characteristics. This is directly relevant to patient impacts.

We explain our statutory duties, how we have addressed them and how implementation of the proposals would help achieve them, more widely in further detail in Appendix 1 of this document.

1.2 Structure of this document

The structure of this document is intended to be broadly consistent with the structure of the consultation notice. It is organised into the following sections:

- In **Section 2**, we set out our approach to impact assessment for the proposals in the consultation notice, and the objectives of our analysis.
- In **Section 3**, we present our assessment of the financial impact on providers and commissioners of the proposed changes to national prices, including specific prices and currencies (see Sections 4 and 5 of the consultation notice). We assess the impact of these proposals on patients qualitatively.
- In **Section 4**, we present our assessment of the impact of changes to the national variations that apply to national prices, including new best practice tariffs, changes to the emergency readmission rule, changes to the marginal rate rule, and flexibility on the use of national prices for chemotherapy and radiography (see Section 6 of the consultation notice).
- In **Section 5**, we present our assessment of the impact of changes to the rules for locally determined prices, including local variations, local modifications and the rules for setting prices for services without a national price (see Section 7 of the consultation notice).

- In **Section 6**, we set out our analysis of the aggregate impact of the proposed changes on competition, rural proofing, small firms and individuals who share protected characteristics as defined in the Equality Act 2010.

2 Approach to impact assessment for 2014/15

Consistent with our duty to act in the best interests of patients, the primary objective of this impact assessment is to ensure that the proposals in the consultation notice are in the best interests of patients. Patient impacts might arise directly (e.g. via impacts on patient choice) or indirectly (e.g. via impacts on commissioners' budgets or on the financial stability of providers and their ability to provide health care services).

To meet this objective, we need to construct realistic scenarios to show the impacts of NHS England and Monitor's proposals. These scenarios need to cover both the things that we expect to happen, and realistic alternative cases (particularly where there is a risk to patient interests if NHS England and Monitor's expectations are not met).

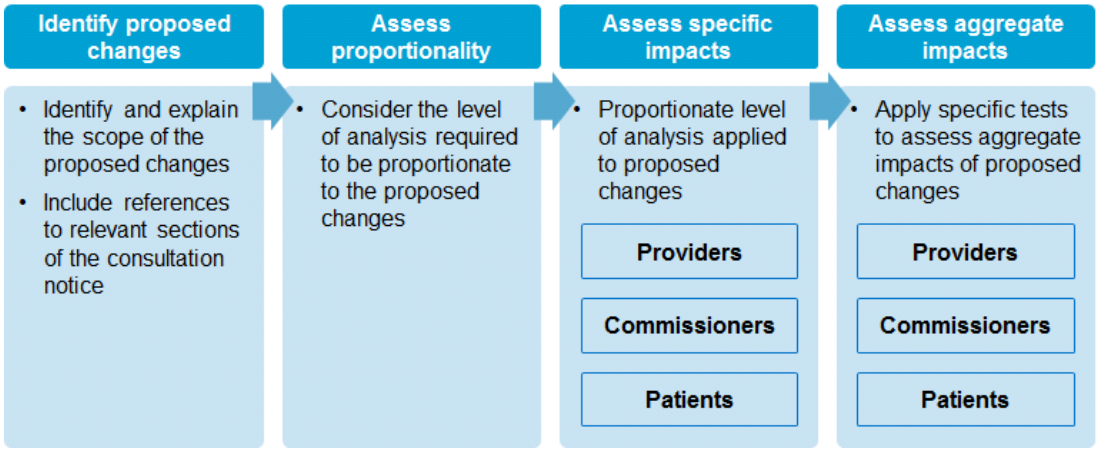
The primary objective of this impact assessment is to ensure that the proposals set out in the consultation notice are in the best interests of patients. We refer to these changes as the 'proposed changes'. Specifically, this document is intended to assess:

- the expected financial impact on **providers**;
- the expected financial impact on **commissioners**; and
- the expected impact on the **quality of services for patients**.

We have developed a framework for assessing the impact of the proposed changes to the national tariff on providers, commissioners and patients.

This process is summarised in Figure 2-1 below and each step is explained in more detail below.

Figure 2-1: Framework for impact assessment



Our approach to the impact assessment comprises the following steps:

- First, identify and explain the scope of the proposed changes by reference to the relevant sections or subsections of the consultation notice (Subsection 2.1 in this document);
- Second, consider the type and level of analysis required to perform a proportionate assessment of the expected impacts (Subsection 2.2 in this document);
- Third, apply a consistent analytical approach to assess the expected impacts for specific proposed changes (Subsection 2.3 in this document); and
- Fourth, consider the expected impact of all proposed changes in aggregate, using specific tests where appropriate (Subsection 2.4 in this document).

We discuss each step in turn, and then set out relevant data sources in Subsection 2.5 of this document.

2.1 Scope of proposed changes

The scope of this impact assessment is defined by the scope of the 2014/15 national tariff. It covers the proposed changes to the national tariff for 2014/15 as set out in the consultation notice.

There are three broad categories of changes:

- Changes to national prices or currencies. This includes cost uplift and efficiency adjustments, which are used in the calculation of all national prices, and new or updated national prices (and associated changes in currencies). These changes are explained in Sections 4 and 5 of the consultation notice.
- Changes to national variations which apply to national prices. This includes changes to the marginal rate rule, changes to the emergency readmission rule, flexibility on the use of national prices for chemotherapy and radiography, and the introduction of new best practice tariffs for certain services. These changes are explained in Section 6 of the consultation notice.
- Changes to the rules that allow providers and commissioners to vary nationally determined prices (i.e. national prices after national variations have been applied) and national currencies, or agree local prices when there are no nationally determined prices. This includes changes to local variations, the introduction of local modifications as required by the 2012 Act, and changes to the rules for local price setting. These changes are explained in Section 7 of the consultation notice.

Our impact assessment is intended to assess the impact of *changes* in the national tariff. It does not consider the ongoing impact of existing policies which are not proposed to change for 2014/15.

In our preliminary impact assessment we published in June, we considered the impact of the proposed changes for enforcement. We received no comment on our analysis and therefore do not re-visit our assessment of enforcement in this document.

Where we describe the proposed changes set out in the consultation notice in this document, we do so for the benefit of the reader. This is for informational purposes only, and should not be interpreted as providing further guidance on the proposed changes in the consultation notice or superseding the consultation notice in any way.

2.2 Proportionality of analysis

We have assessed the level of analysis required for the proposed changes in the consultation notice. In performing this assessment, we have had regard to:

- the HM Treasury Green Book, which provides general guidance on policy appraisal and impact assessment; and
- the Department for Business Innovation and Skills (BIS) Impact Assessment Toolkit, which provides guidance specifically on the assessment of regulatory changes.

Both sources advise that the level of analysis should be in proportion to the resources and data available for analysis and the potential scale of the impact. To determine the level of analysis conducted for the proposed changes, we considered the key drivers of proportionality in the BIS Impact Assessment Toolkit. These drivers are:

- the level of interest and sensitivity surrounding the policy;
- the degree to which the policy is novel, contentious or irreversible;
- the stage of policy development;
- the scale, duration and distribution of expected impact;
- the level of uncertainty around likely impacts;
- the data already available and resources required to gather further data; and
- the time available for policy development.

Table 2-1 below reflects our application of these principles to the proposed changes set out in the consultation notice. We have sought to apply quantitative analysis where possible and practicable. However, the nature of many of the proposed changes mean that it has not been possible for us to assess all of the impacts quantitatively, and we have had to undertake qualitative analysis in some cases as well.

Table 2-1: Impact assessments presented in this document

Category	Proposed changes	Analysis presented in this document
National currencies and prices (Sections 4 and 5 of the consultation notice)	Cost uplift factors and efficiency requirement	Quantitative assessment of impacts on providers and commissioners. Qualitative assessment of impacts on patients.
	Specific HRG and tariff changes	Quantitative and qualitative assessment of impacts on providers and commissioners. Qualitative assessment of impacts on patients.
National variations (Section 6 of the consultation notice)	Marginal rate rule	Qualitative assessment of impacts on providers, commissioners and patients.
	Emergency readmissions rule	Qualitative assessment of impacts on providers, commissioners and patients.
	Chemotherapy and external beam radiography	Quantitative assessment of impacts on providers, commissioners. Qualitative assessment of impacts on patients.
	New best practice tariff variations	Qualitative assessment of impacts on providers, commissioners and patients.
Locally determined prices (Section 7 of the consultation notice)	Local variations	Qualitative assessment of impacts on providers, commissioners and patients.
	Local modifications	Qualitative assessment of impacts on providers, commissioners and patients.
	Services without a national price	Qualitative assessment of impacts on providers, commissioners and patients.

2.3 Analysis of proposed changes

We have developed a consistent analytical framework that we apply to the proposed changes in the consultation notice, adjusting the level of detail appropriately. This framework comprises the following steps:

- First, assess the expected financial impact on public sector providers of the proposed change, using quantitative analysis where appropriate. This may involve analysis of the incremental effect on the financial viability of providers as a result of the changes.
- Second, assess the expected financial impact on commissioners of the proposed change, using quantitative analysis where appropriate. This may involve analysis of whether the commissioner would be able to afford the same mix of services, given the proposed change and the latest commissioning budget allocations.
- Third, assess the expected impact on the quality and availability of services provided to patients, based on changes in the financial viability of providers. If there is significant risk to the viability of a provider, or particular services provided by a provider, this may increase the risk that quality for patients is reduced. Equally, if commissioners are not able to afford the same mix of services, they may change the services commissioned. In most cases, we use qualitative analysis to consider these impacts.

In each case, we compare the effect of the proposed change to the counterfactual case where there was no change to the national tariff and existing rules continued to apply. Where possible and proportionate, we use sensitivity analysis to test our results. We have, for example, considered a number of scenarios where providers do not meet the efficiency expectations of NHS England and Monitor.

2.4 Specific tests

We assess the expected impact on specific patient groups who share protected characteristics as defined in the Equality Act 2010, by considering whether particular groups of providers and commissioners, and therefore patients, are disproportionately affected by the proposed changes. We use specific quantitative and qualitative tests to address these issues.

For this analysis, we compare the effect of the proposed change to the counterfactual case where there was no change to the national tariff and existing rules continued to apply.

2.5 Key information sources

This impact assessment relies on a number of data sources. The principal data sources we use are listed in Table 2-2 below. For each case, we use the latest available complete data set.

Table 2-2: Key information relied upon in this impact assessment

Source	Description
HES MMES 2012/13	This is detailed information collected for each patient receiving acute medical care in the NHS. It consists of data about each individual episode of care that a patient receives, who provided this care and who commissioned the care.
FIMS and FTC 2012/13	FIMS is the audited financial data of each NHS Trust. This has to be submitted each year to the Department of Health (DH) in the same way that a private company must prepare and present a set of financial accounts and files them with Companies House. FTC is the audited financial data for each foundation trust. As with NHS Trusts, each foundation trust must submit this to DH each year.
National Tariff 2013/14	The list of services covered by the national tariff including the prices set for the 2013/14 financial year as well as the associated business rules.
NHS budgets 2013/14	The published budgets of CCGs showing us the budget allocations for the current financial year.
Engagement grouper 2014/15	The published engagement grouper which can group HES data into the correct HRG ready to be used by the Pricing Engine, along with the Tariff Engine, to calculate tariff revenues for each provider.

3 National currencies and prices

NHS England and Monitor's proposed approach to national currencies, prices, and rules in the national tariff is to keep relative prices broadly stable. We do this by using 2013/14 prices as the starting point for our calculations.

We propose to update the 2013/14 national prices to reflect both:

- the aggregate expected change in providers' input costs during 2014/15; and
- NHS England and Monitor's expectations for providers to deliver services more efficiently (the "efficiency requirement").

In addition, we need to ensure that the national tariff is still clinically relevant and sufficiently up-to-date, and for this reason, we propose to make a limited number of changes to some currencies.

These changes – in currencies and prices – directly affect the expenditure of commissioners, and the income of providers. The impacts on patients are of utmost importance but are therefore indirect, since both commissioners and providers can affect the volume and mix of services provided to patients.

In this section, we calculate the impacts of the proposed changes on commissioners and providers, and then describe how these impacts flow through to patients. We do this separately for:

- the general 'rollover' update of national prices, reflecting the cost uplift factors and efficiency requirement; and
- the currency updates (and associated new or amended prices) to support clinical development.

3.1 Changes to national prices

NHS England and Monitor propose to adjust prices generally for cost pressures on providers (cost uplifts), offset by expectations for improved efficiency on the part of providers. This is described in Subsections 5.2 to 5.4 of the consultation notice.

As described in Subsection 5.5 of the consultation notice, on average, and not taking account of increases in contributions to the Clinical Negligence Scheme for Trusts (CNST) that we allocate to specific groups of HRGs, the overall draft prices for 2014/15 are around 1.9% lower (in nominal terms) than their corresponding 2013/14 prices.

For tariff services, a final adjustment is made at a HRG sub-chapter level to reflect the impact of increased CNST costs. This has the impact of raising prices on tariff services by an average of 0.3 percentage points, so that average draft prices for tariff services are around 1.6% lower than corresponding 2013/14 prices[1].

This is illustrated in Table 3-1 below.

Table 3-1: Net tariff uplift calculation

Price Change Component	Price Change Amount
Inflation	+ 1.9%
Capital charges	+ 0.2%
Service enhancements	0.0%
Subtotal tariff uplift	**+ 2.1%**
Efficiency requirement	- 4.0%
CNST[5]	+ 0.3%
Total net tariff uplift	**- 1.6%**

The decrease in prices by 1.6% is NHS England and Monitor's current best estimate based on data sources available (some of the proposed cost uplift factors will be finalised later in the year). Full details of how we have calculated the cost uplift factors can be found in Subsection 5.3 of the consultation notice.

1 CNST varies depending on the HRG sub-chapter concerned. We have taken an average of the CNST rate across all tariffs. This amounts to 0.3% which can be added to the other inflationary items to arrive at a total cost uplift figure of 2.4%. Providers whose service mix includes a higher or lower average of maternity services may find that they have a slightly higher or lower cost uplift.

Below, we describe:

- the analysis we have performed;
- the impact on providers;
- the impact on commissioners; and
- the impact on patients (which ultimately flows from the impact on providers and commissioners).

3.1.1 Our analysis

We have developed a financial model to assess quantitatively the impact of some of the proposed changes to national prices. This model uses Hospital Episode Statistics (HES) data, which is then converted into Healthcare Resource Group (HRG) codes, to estimate the total revenues for NHS foundation trusts and NHS trust from services with national prices. It uses the same data to estimate the total spend on these services for each commissioner. With this model we are able to quantify the effect on providers and commissioners of changes to national prices (under the assumption that providers use nationally determined prices for service with national prices).

In summary, we use a static analysis of activity in 2012/13 to compare the income providers would receive using the proposed national prices for 2014/15 to the income they would receive using national prices for 2013/14. We adjust this analysis to take into account cost uplifts and improvements in provider efficiency, as well as changes to commissioner budgets. We combined this analysis with audited financial data to perform specific financial tests.

We have not attempted to model changes in supply and demand resulting from the new tariff. As a result, our quantitative impact assessment captures only the first order impact of changes in national prices.

We calculate the impact of the proposed changes to national prices on revenues by comparing our estimates of each provider's revenues in 2013/14 and 2014/15. To calculate the full financial impact of the changes, we also take into account expected efficiencies by the providers. This approach assumes that activity has not changed between 2012/13 and 2014/15.

For commissioners, we calculate the change of spend between 2013/14 and 2014/15 as a result of the change in national prices, assuming that for each year, the mix of services is the same as in 2012/13. We compare this change in expenditure against the change in commissioning budgets for each commissioner, to determine the impact on the affordability of the services the commissioner has previously commissioned. Other things being equal, the total spent on services with national prices increases or decreases as a result of changes to national prices. This approach assumes that activity has not changed for the two years between 2012/13 and 2014/15.

Encapsulated in this approach are the following assumptions:

- the service mix and volume of activity in 2013/14 and 2014/15 is the same as in 2012/13;
- in 2013/14 and 2014/15, the costs for all services increase in line with tariff cost uplifts;
- in 2013/14 and 2014/15, all providers achieve efficiency gains equal to the efficiency requirement in the national tariff;
- no providers merge, enter or exit the market; and
- no commissioners merge or separate.

We assess also the impact of the proposed national tariff under a 'sensitivity scenario' where providers do not achieve our expectations on efficiency. In this scenario, we model instead that all providers achieve efficiency of one percentage point below the requirement in the tariff in both 2013/14 and 2014/15.

The model clearly simplifies the impact on providers and commissioners and does not reflect some of the complex changes that have taken place since 2012/13. However, simplification is a necessary part of any financial model and we believe that this model reflects a proportionate level of analysis.

For commissioners, we do not have access to the same level of detailed financial data as we do for providers. We have therefore set the change in tariff services expenditure in the context of commissioner budgets.

3.1.2 Impact on providers

We have considered the impact of the tariff change on providers using four financial tests under two scenarios. We compared these against a starting point of the current financial position of each provider. The outputs of these tests enable us to determine the level of risk that setting a 4% efficiency requirement poses to financial viability of each provider.

The four financial tests were:

- **Surplus/deficit (normalised).** Broadly, this expresses the underlying difference between income and expenditure for a provider, after adjusting for certain one-off impacts.
- **Surplus/deficit (normalised) with cash and cash equivalents.** This is the same as above, but cash (and other assets that can be considered equivalent to cash, such as an investment in government bonds) are included.
- **Liquidity days**. Broadly, this expresses how many days' worth of operating expenses the provider could afford with its cash.
- **Capital Service Capacity**. Broadly, this expresses the ability of a provider to pay its capital servicing costs (e.g. the principle repayments and interest on any loans) out of its income.

The latter two tests are familiar to NHS foundation trusts as they form part of the *Risk Assessment Framework* (RAF) tests used to ascertain continuity of service risk.

A technical description of these financial tests is provided out in Appendix 2 of this document.

The two main scenarios we ran were:

- our expected case, where actual cost pressures match proposed cost uplift pressures in 2013/14 and 2014/15, and providers achieve the efficiency savings that we expect over the same period (4% per year); and
- a 'sensitivity scenario': as above, but all providers achieve efficiency savings of 3% in 2013/14 and 2014/15.

The second scenario emulates the risk that providers do not meet the efficiency requirement that we consider is reasonable for 2014/15[2].

The results of each of these tests are presented in the figures below, which include both illustrations and summary tables.

[2] We also examine another scenario, described later in this subsection, in which providers achieved efficiency gains of 4.5%.

Normalised surpluses and deficits

We began by calculating the normalised surplus/deficit position for providers, using providers' audited accounts for 2012/13[3]. Figure 3-1 shows this, with providers organised from left to right according to surplus/deficit position.

Figure 3-1: Normalised provider surpluses / deficits 2012/13

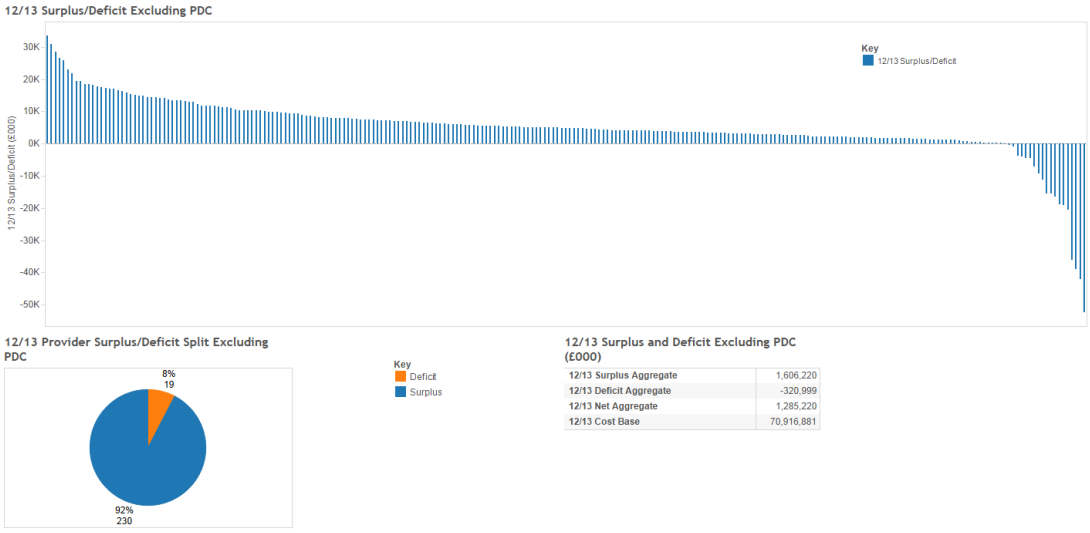


Figure 3-1 shows that, at the end of the 2012/13 financial year:

- at an aggregate level, providers have a net surplus of £1.3 billion before the Public Dividend Capital (PDC) payment is made (that is, surpluses of £1.6 billion less deficits of £0.3 billion); and
- 8% of providers record a normalised deficit before taking the PDC payment into account.

Next, we calculated the financial position of the providers expected two years after the end of the 2012/13 financial year (i.e. the end of 2014/15). We did this in the following way:

- take the annual cost uplift of +2.4% x 2 (to reflect the time period between 2012/13 and 2014/15); and
- subtract the efficiency adjustment of 4% x 2 (years).

The output of these calculations gives us an adjustment of -3.2%.

[3] See Appendix 2 for a technical definition of normalised surplus/deficit.

We apply this adjustment to all revenues and costs[4]. This tells us what we expect the surplus/deficit position of the providers to look like if they *all* lower *all* of their costs in line with NHS England and Monitor's efficiency expectations.

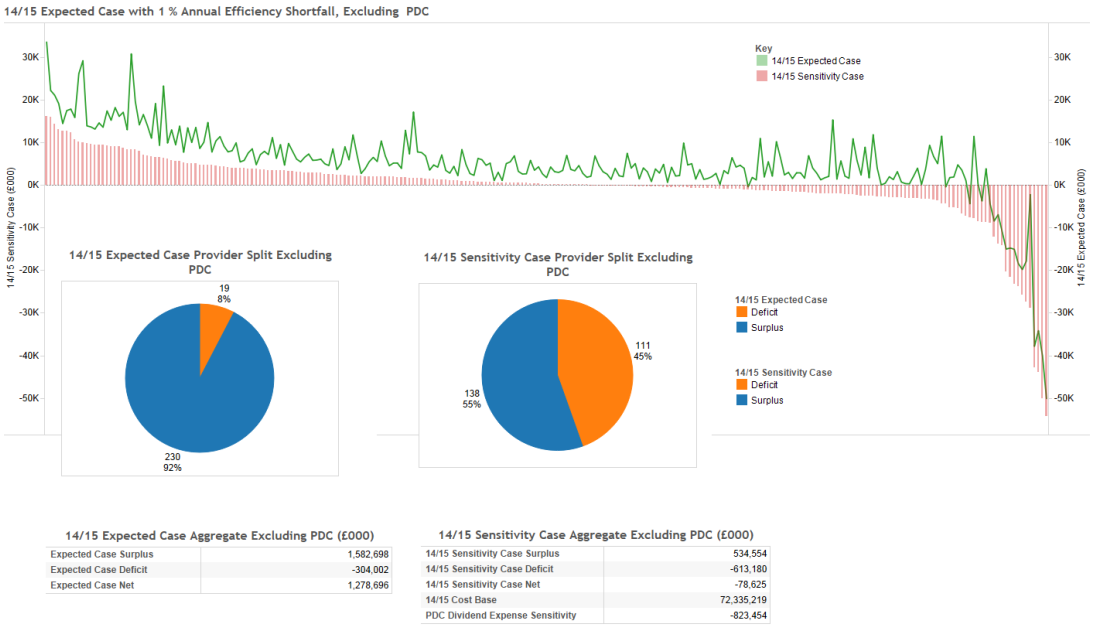
The green line in Figure 3-2 below shows this position where costs and income adjust in line with each other[5]. As Figure 3-2 illustrates, there are still only 19 providers in a deficit position and, at an aggregate level, providers still have a net surplus of about £1.3 billion. The similarity between this result and our 2012/13 starting point is unsurprising, because both costs and incomes have been adjusted by the same percentage.

The red line in Figure 3-2 shows the surpluses and deficits under the scenario where *all* providers missed their efficiency requirements by one percentage point each year, i.e. they only reduce unit costs by 3% in both 2013/14 and 2014/15. If this scenario were to transpire, then assuming volumes of activity and casemix all remain the same we estimate that 111 providers (or 45% of the total) would be in financial deficit. At an aggregate level, provider deficits would slightly outweigh surpluses by £79 million. Clearly, under this sensitivity case scenario, this represents a significant deterioration in providers' financial positions.

[4] For the purposes of this impact assessment, we have not been able to differentiate between services within the scope of the national tariff and services outside of the scope of the national tariff. However, given that we expect NHS England and Monitor's cost uplift factors and efficiency requirement to be used as the basis for negotiation (for currencies without national prices), we consider this is a reasonable assumption to use.

[5] We have not presented a separate chart for this 'expected case'.

Figure 3-2: Provider surpluses/deficits 2014/15 expected and with annual one percentage point efficiency shortfall



14/15 Expected Case Aggregate Excluding PDC (£000)

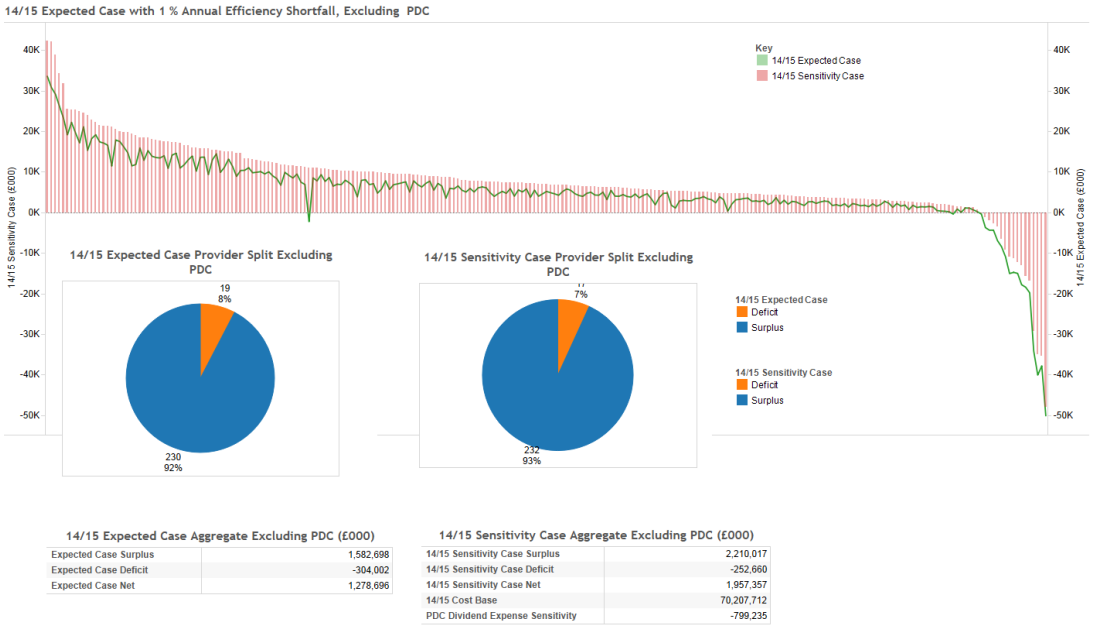
Expected Case Surplus	1,582,698
Expected Case Deficit	-304,002
Expected Case Net	1,278,696

14/15 Sensitivity Case Aggregate Excluding PDC (£000)

14/15 Sensitivity Case Surplus	534,554
14/15 Sensitivity Case Deficit	-613,180
14/15 Sensitivity Case Net	-78,625
14/15 Cost Base	72,335,219
PDC Dividend Expense Sensitivity	-823,454

We also ran a scenario where providers achieved 4.5% efficiency savings each year (i.e. in excess of the efficiency requirement of 4%). The impact was to increase providers' surplus or reduce the size of any provider deficits as shown in Figure 3-3 below.

Figure 3-3 Provider surpluses/deficits 2014/15 expected and with annual efficiency gains of 4.5%



14/15 Expected Case Aggregate Excluding PDC (£000)

Expected Case Surplus	1,582,698
Expected Case Deficit	-304,002
Expected Case Net	1,278,696

14/15 Sensitivity Case Aggregate Excluding PDC (£000)

14/15 Sensitivity Case Surplus	2,210,017
14/15 Sensitivity Case Deficit	-252,660
14/15 Sensitivity Case Net	1,957,357
14/15 Cost Base	70,207,712
PDC Dividend Expense Sensitivity	-799,235

An improvement across all providers can be seen. The green line shows the expected surplus/deficit position of providers assuming they meet their efficiency targets. The red bars show the surplus/deficit positions when providers exceed their target and achieve 4.5% efficiency cost savings.

Under this additional scenario, two providers move from a deficit to a surplus and, at an aggregate level, provider surpluses outweigh deficits by £2 billion.

Normalised margins (surpluses / deficits) with cash and cash equivalents

We considered whether holdings of cash and cash equivalents would cushion the immediate negative financial impacts of any deficits. In Figure3-4 below, we illustrate the effects on the expected surplus/deficit position of providers when cash and cash equivalent balances are added to their operating surplus/deficit positions. We also show the surplus/deficit position with cash and cash equivalents for the sensitivity scenario, where providers miss their efficiency requirements by 1% in 2013/14 and 2014/15.

Figure 3-4: Provider surpluses/deficits 2014/15 after cash and cash equivalents

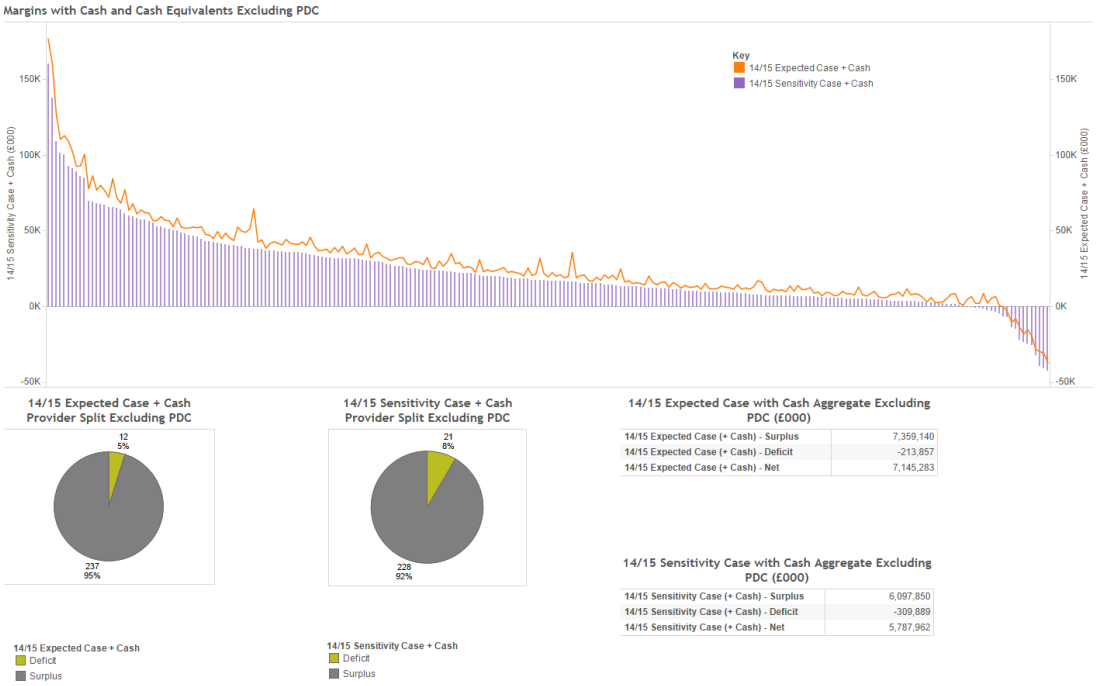


Figure 3-4 shows that, for providers that would otherwise be in deficit if the efficiency requirement was missed by 1% each year, the cash and cash equivalents held would absorb the short-term impact.

We also note that, after adding any cash and cash equivalent balances:

- if all providers lower costs in line with efficiency expectations, 5% of providers show a deficit; and
- under our sensitivity scenario, 8% of providers would be in deficit.

This analysis gives us some reassurance that providers will not be financially distressed in the short term even if they were all to fall short of NHS England and Monitor's efficiency expectations. However, we do recognise that in some cases, cash and cash equivalents held by providers may be earmarked for operating expenses to be paid within the next financial quarter or for projects involving capital expenditure and therefore only provides a degree of reassurance.

Liquidity days

As an extension of our cash and cash equivalents analysis, we examined each provider's 'liquidity days'. This is a metric which measures how many days of operating costs providers can fund out of cash reserves, after taking account of all their current liabilities[6]. The lower the liquidity days, the higher the risk that, in any given month, a provider will not have sufficient cash to pay its bills.

Technically, we have defined liquidity days, for the purpose of this impact assessment as follows:

Liquidity days = (Cash for liquidity purposes x 360) / annual operating expenses

Liquidity days can be assessed using the RAF scale of 1 to 4, where:

- 4 is best (meaning that the liquidity days metric is equal to or greater than 0 days); and
- 1 is worst (meaning that the liquidity days metric is less than -14 days).

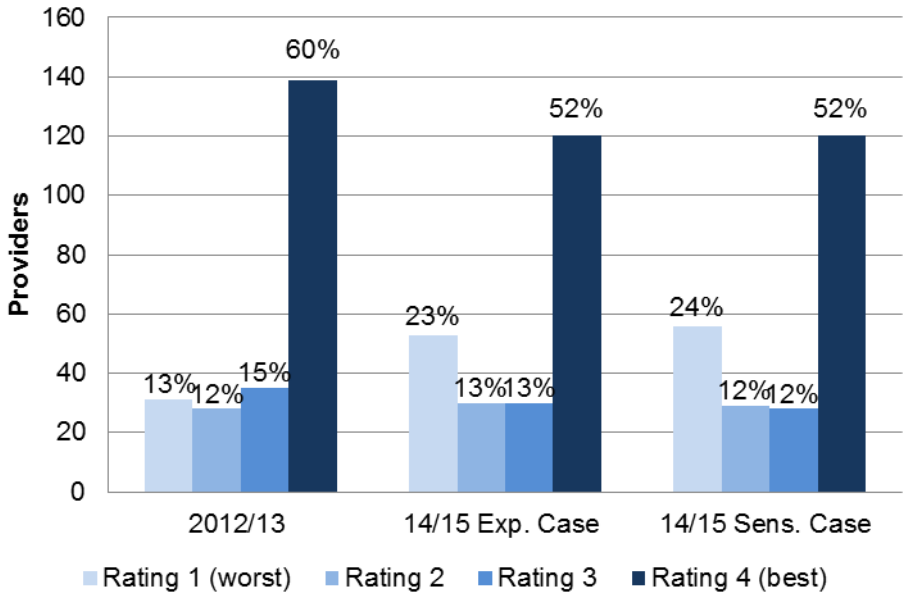
As with the financial tests above, we ran a scenario to simulate how liquidity days would change if providers missed the efficiency requirement by one percentage point each year.

The results are shown in Figure 3-5 below[7].

[6] This test is one of Monitor's continuity of services tests. We apply this test to NHS foundation trusts on a quarterly basis to check their financial viability.

[7] The percentage values in this figure do not always sum exactly to 100%. This is caused by rounding errors.

Figure 3-5: Provider liquidity days ratings



Under the sensitivity scenario, we can see a slight deterioration overall across providers as their costs and revenues decline, suggesting that their operating expenses are large compared to their adjusted cash reserves (seen in the 2014/15 expected case above). However, failure to meet efficiency targets by one percentage point each year has almost no impact on providers' liquidity days ratings. This reinforces the point that the cash reserves help to cushion providers against short-term deficits.

This test gives us more reassurance providers will be able to pay their operating costs, even if they fall short of NHS England and Monitor's efficiency expectations.

Capital Service Capacity

The Capital Service Capacity (CSC) test tells us how many times providers' adjusted annual surpluses can cover their debt servicing costs (interest and principal repayments[8].

[8] This test is one of Monitor's continuity of services tests. We apply this test to NHS foundation trusts to check their financial viability

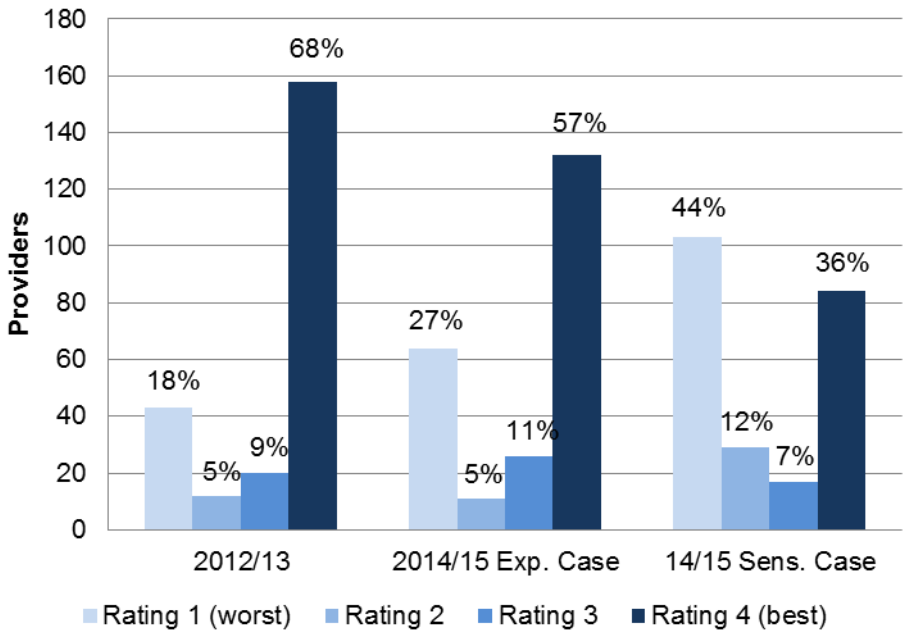
As with the tests above, we ran this test with the 'as is' position from the 2012/13 FIMS and FTC data, and then under two scenarios for 2014/15: our expected case and the sensitivity scenario.

As with liquidity days, CSC can be assessed using the RAF scale of 1 to 4, where:

- 4 is best (meaning that a provider has enough annual revenue available to cover its annual debt servicing obligations more than or equal to 2.5 times); and
- 1 is worst (meaning that a provider has enough annual revenue available to cover its annual debt servicing obligations less than 1.25 times).

The results are shown in Figure 3-6 below[9].

Figure 3-6: Provider Capital Service Capacity ratings



[9] The percentage values in this figure do not always sum exactly to 100%. This is caused by rounding errors.

Reducing both revenues and debt costs by 3.2% over the two years from 2012/13 to 2014/15 results in a small deterioration of CSC in our expected case. However, failing to meet efficiency requirements by 1% each year leads to a significant degradation of CSC as costs rise relative to income. Our analysis suggests that the number proportion of trusts providers close to, or in a position of *not* being able to cover service their debts obligations will increase from 18% of providers to 44%[10] (see Figure 3-6 above). More providers may find themselves in a position where they have to ensure that they maintain net income and/or manage their debt servicing costs down. The latter may not be possible in the short term so providers will be forced to manage costs very severely. This is one of the intended consequences of the efficiency requirement that we are applying.

This analysis highlights the risks to providers should they fail to manage their costs downwards successfully. If they do not, we may see a limited number of providers entering special administration or requiring additional support from other sources.

3.1.3 Impact on commissioners

Under the proposed changes in the consultation notice, the prices paid for tariff services would each reduce by 1.6% in 2014/15 (compared to 2013/14), meaning that, all else being equal, commissioners could either buy more services, or spend less on tariff services overall.

Last year, CCGs' budgets increased by 2.3% in aggregate. If this continued for 2014/15, then commissioners would have more purchasing power than 2013/14.

3.1.4 Impact on patients

In this subsection, we draw together our analysis of providers and commissioners to consider whether NHS England and Monitor's national price proposals will be in the best interests of patients. In it, we consider both:

- the impact of the national pricing proposals in 2014/15, compared with leaving prices at their 2013/14 level, assuming that providers meet the efficiency requirement; and

[10] Our sensitivity applies to all costs, including financial costs. In reality, these costs may have fixed repayment rates or fixed interest rates. In such a case, our sensitivity (raising costs by 1% each year, or 2% over the period) might not apply to these costs and our analysis will therefore overstate the impact of the sensitivity scenario.

- the sensitivity scenario where providers fall short of NHS England and Monitor's efficiency expectation by 1% per year in 2013/14 and 2014/15.

Impacts – expected scenario

The proposal in the consultation notice is that, for 2014/15, national prices for tariff services will decrease by 1.6% on average in 2014/15[11].

Therefore, given constant activity levels and casemix, provider revenues will fall by 1.6% in 2014/15. In the expected scenario, provider costs will reduce at the same rate, so the impacts of the price proposals on providers should be limited.

We also expect that commissioners will have more spending power. This will allow commissioners some flexibility to purchase a combination of:

- additional services;
- more complex services; and/or
- higher quality services.

In short, we expect that the proposed changes will have positive impacts for patients.

Impacts – sensitivity scenario

We acknowledge that a 4% efficiency requirement is a stretching requirement. If providers fall short of this requirement by 1%, providers' financial positions would be less favourable:

- an additional 37% would be pushed into a deficit position in 2014/15; and
- the cushion of debt coverage from revenues (CSC) is pushed below 1.25 times for up to 44% of providers compared to around 20% currently.

However, in this scenario, where providers fall short of the requirement by 1%, most providers will not experience any significant decline in their ability to pay their operating costs in a timely fashion. The vast majority of providers should be able to absorb the resultant deficits in 2014/15.

[11] This includes the average impact of CNST cost uplifts. Non-tariff prices would decrease by 1.6%.

In the event of financial stress, we expect that providers will work with commissioners to manage the volume and mix of services, and to make local arrangements that will maximise value for patients. Further, providers with unavoidable, structurally higher costs that make the provision of specific services uneconomic at the nationally determined price may be eligible for local modifications to prices[12].

Commissioners would not be directly affected by providers falling short of efficiency requirements, but providers might respond to financial pressure by taking measures that affect commissioning decisions. For example, some providers might withdraw some of their services. Even in these cases, other parts of the regulatory framework, such as that associated with commissioner requested services, will ensure that patients continue to have access to all of the services that they need.

The above notwithstanding, the financial pressures that we have identified are not so severe and widespread that NHS England and Monitor would need to adjust the pricing proposals.

Conclusions on impacts on patients

We consider this impact assessment supports the view in Section 5 of the consultation notice that the proposed changes for national prices will have a positive impact on patients. We recognise that providers failing to meet the efficiency requirement may experience negative financial impacts, but this is an important aspect of the incentives structure of fixed national prices.

For years beyond 2014/15, we are likely to propose a different method for setting national prices, based on updated cost data (which is likely to include reference costs data as well as potentially PLICS[13] data). As pricing methods change over time, so will the approaches we take to impact assessment.

3.2 Currency updates to support clinical development

The table overleaf sets out the currency (and associated price) changes proposed in the consultation notice, together with how we have assessed them.

[12] See Subsection 7.3 of the consultation notice.

[13] A Patient-Level Information and Costing Systems (PLICS) pilot collection was conducted by Monitor in the summer of 2013.

Table 3-2: Summary of currency (and associated price) changes for 2014/15

Description of change	Reference in consultation notice	New/revised price for 2014/15?	Impact assessment conducted, and reference to this document
New HRGs			
Kidney and ureter: reflect relative costs of laparoscopic and open procedures	4.4.1	Yes	Quantitative (Subsection 3.2.1)
Complex bronchoscopy: correct for under-reimbursement	4.4.1	Yes	Qualitative (Subsection 3.2.2)
Complex therapeutic endoscopy	4.4.1	No	Not assessed
Acute kidney injury: identify dialysis procedures	4.4.1	No	Not assessed
HRG design changes			
STARR: adjustment for under-reimbursement	4.4.2	No	Quantitative (Subsection 3.2.1)
Fractional flow reserve (FFR): correct for under-reimbursement	4.4.2	No	Quantitative (Subsection 3.2.1)
Orthopaedics: better reflect the costs of treatment for physical abuse	4.4.2	No	Quantitative (Subsection 3.2.1)
Spinal surgery: correct for under-reimbursement	4.4.2	No	Quantitative (Subsection 3.2.1)
Electroencephalograph telemetry: correct for under-reimbursement	4.4.2	No	Quantitative (Subsection 3.2.1)
Intravenous induction of labour: discourage incorrect coding	4.4.2	No	Not assessed separately. Forms part of maternity pathways.
General coding: encourage coding of ‘other’ and ‘unspecified’ procedures using correct chapters	4.4.2	No	Not assessed
Other HRG changes			
Health assessments for looked after children (out-of-area)	4.4.4		Qualitative (Subsection 3.2.2)
Corrected price for RC31Z	4.4.5		Not assessed
Change from mandatory to non-mandatory price for RA42Z	4.4.6		Qualitative (Subsection 3.2.2)
New or amended best practice tariffs			
New best practice tariff: primary hip and knee replacements	4.4.3		Quantitative (Subsection 3.2.3)
Amended best practice tariff: paediatric diabetes	4.4.3		Quantitative (Subsection 3.2.3)
Amended best practice tariff: major trauma	4.4.3		Quantitative (Subsection 3.2.3)

3.2.1 HRG and tariff changes, quantitative assessment

The method for calculating the impact of specific currency changes is not integrated into the analysis described in the previous section.

To assess the impact of specific HRG changes, we have compared:

- income expected under 2013/14 national prices (using HES activity data from 2011/12); with
- income expected under the proposed 2014/15 national prices (again, using HES activity data from 2011/12).

The results of our *quantitative* impact assessment for the new or amended HRGs shown in Table 3-2 above are presented in Table 3-3 below. The results cover 161 (mostly) acute providers.

Table 3-3: Specific impacts – changes to provider tariff income (at constant activity levels)

	Total change in tariff income (2013/14 to 2014/15)		Due to price changes[14]		Due to HRG design changes[15]	
	£000s	%	£000s	%	£000s	%
Maximum	***960***	***0.9%***	*339*	*0.3%*	*824*	*0.9%*
Average	***62***	***0.0%***	*14*	*0.0%*	*48*	*0.0%*
Minimum	***-86***	***-0.1%***	*-150*	*-0.1%*	*-26*	*0.0%*

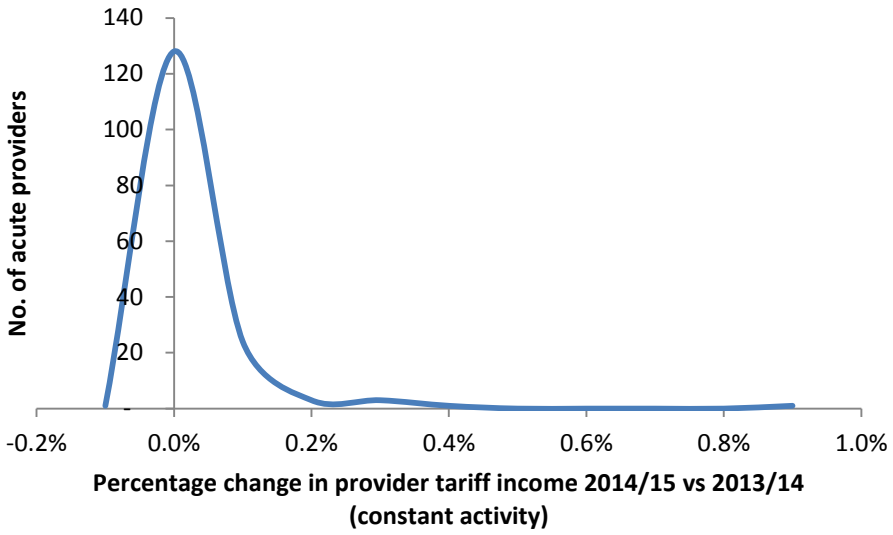
The figures above tell us that, overall, the largest increase to provider tariff income resulting from changes to prices and HRG changes described above is an increase of 0.9% compared with 2013/14 published tariffs based on 2011/12 activity data. The largest decrease in a provider's tariff income is 0.1%. Of this, changes to HRG design account for a larger change than changes in prices.

[14] Price changes relate to laparoscopic nephrectomy and major hepatobiliary procedures (RC31Z).

[15] HRG design changes relate to electroencephalograph telemetry (EEG), spinal surgery, fractional flow reserve, physical abuse/trauma and stapled transanal rectal resection for obstructed defecation syndrome.

We have considered the distribution of the changes in provider tariff income. Of the 161 acute providers analysed, 128 would experience almost no change in their tariff income according to our analysis. As shown in Figure 3-6 below, most acute providers would experience a change in their tariff income in 2014/15 of between -0.1% and +0.2% of their 2013/14 tariff income (based on constant 2011/12 activity levels). The largest reduction in tariff income for any provider is about 0.1% of its projected 2013/14 tariff income.

Figure 3-6: Distribution of acute providers' tariff income change from specific price changes



Based on this analysis, we consider that the impact of the specific HRG and tariff changes (listed at the beginning of this subsection) on providers will be small.

To the extent that these changes make the tariff more clinically up-to-date, we expect that they will have a positive impact on patients, although we have not quantified this effect.

3.2.2 HRG and tariff changes, qualitative assessment

We have assessed the proposed changes to the following services qualitatively:

- complex bronchoscopy;
- health assessments for looked after children (out-of-area); and

- PET CT[16] scans.

We discuss each below.

Complex bronchoscopy

For 2014/15, NHS England and Monitor propose to include a new HRG design and price for complex bronchoscopy. This change will affect about 300 spells in England. The impact on any single provider is not expected to be significant.

Health assessments for looked after children (out-of-area)

For 2014/15, NHS England and Monitor propose to make the tariff for out-of-area health assessments for looked after children mandatory.

Providers and commissioners may be currently using prices which are not the same as the mandated ones. However, the difference is expected to be very small and is unlikely to have a significant impact on any single provider and no adverse impact on patients.

PET CT scans

For 2014/15, NHS England and Monitor propose no longer to mandate the national price for PET CT scans (RA42Z), following feedback that it has been set at a level which is too low to cover costs. The quantum value of this service in England is £6.5 million so this will not have a significant impact on any individual provider or patients.

3.2.3 Best practice tariffs

For 2014/15, NHS England and Monitor propose three changes to best practice tariffs (BPTs). These changes, described in detail in Section 4 of the consultation notice, are:

- a new BPT for primary hip and knee replacement;
- a revised price for the paediatric diabetes BPT; and
- amendments to the BPT for major trauma.

We discuss each below.

[16] Positron emission tomography – computed tomography.

Primary hip and knee replacement BPT

The proposed new BPT for primary hip and knee replacements represents a change to the existing approach. Payment of the proposed BPT to the provider is conditional upon patients reporting an average health gain not significantly below the national average, and the provider adhering to the certain data submission standards[17]. Providers meeting these criteria will receive the best practice tariff price; providers not meeting all of the criteria will receive a price 10% below.

To analyse the impact on providers, we examined the current performance (based on reported PROMs data) of all providers, relative to the criteria set, and determined which would and which would not receive the BPT. The results of this analysis was that:

- For knee replacements, based on their current performance, 37 providers (of which 12 private providers) would not meet the new BPT standard. The total quantum of spend across these 37 providers could fall by up to £6.4 million.
- For hip replacements, based on their current performance, 48 providers (of which 11 private providers) would not meet the new BPT standard. The total quantum of spend across these 48 providers could fall by up to £8.3 million.

Table 3-4 below shows the maximum, minimum and average financial impacts on the group of providers impacted by the new primary hip and knee BPTs.

Table 3-4: Impact on provider income from introducing primary hip and knee BPTs

	Knee replacements		Hip replacements	
	£000s	%	£000s	%
Maximum	*-978*	*-0.28%*	*-490*	*-0.69%*
Average	*-226*	*-0.08%*	*-133*	*-0.06%*
Minimum	*-3*	*-0.02%*	*-2*	*-0.01%*

[17] See Subsection 4.4.1 of the consultation notice.

As shown in Table 3-4 above, the largest financial impact on a single provider from the introduction of the primary knee replacement BPT is an income reduction of £978,000. This represents a reduction of 0.28% of the total income for the provider in question.

These impacts are a high estimate of the impact that can be expected. These BPTs are a replacement of an old BPT; providers were therefore following a different process-based BPT. Nationally, all providers were achieving the existing BPT. We expect that providers will now put in place or adapt existing systems and processes to ensure that the replacement BPT thresholds are met.

It is our expectation that the financial incentive for providers to meet best practice would maintain or improve service quality for patients.

In the proposed changes, we recognise that there are circumstances where some providers will not be able to demonstrate that they meet all of the best practice criteria, but where it would be inappropriate for the full BPT not to be paid. We have therefore introduced a national variation to assist the transition to this new payment approach (see Section 6 of the consultation notice). The impact assessment of this transitional arrangement is described in Subsection 4.4 of this document.

Paediatric diabetes BPT

We are proposing to revise the price of this BPT to reflect the cost of unavoidable admissions. We have calculated the additional cost of a year of care associated with unavoidable admissions. The price of the BPT has increased by £224 to reflect this.

Providers will now have to fulfil some additional requirements to qualify for the BPT. If they do not do so, they will experience a small decrease in income. This is expected to be limited across providers as the total quantum value of paediatric diabetes care is around £10 million annually.

It is our expectation that the financial incentive for providers to meet best practice would maintain or improve service quality for patients, and the additional payment (to reflect the cost of unavoidable admissions) would ensure this service is appropriately reimbursed.

Major trauma BPT

The existing BPT for major trauma has been amended and now includes additional obligations such as a requirement to submit data to the Trauma Audit and Research Network (TARN) within a 25 day period (previously this was a 40 day period).

We have used data from Q1 2013/14 to reflect movements towards the current best practice characteristics. We estimate that, at an aggregate level, applying the new BPT criteria to the 2013/14 Q1 data (which we have annualised) shows a quantum level of activity with a value of £17 million (i.e. incomes from major trauma treatment could fall by this amount if we apply the proposed BPT to current performance levels). However, this should again be considered an upper estimate as it is likely providers will respond to the change by improving their data submissions and other aspects of best practice care.

The financial incentive for providers to meet best practice will maintain or improve service quality for patients.

4 National variations

Section 6 of the consultation notice sets out the national variations that we propose to specify in the national tariff, under sections 116(4)(a) and 118(5)(a) of the 2012 Act. These variations are to be applied to the national prices as determined in Section 5 of the consultation notice.

There are four types of national variations, which are each explained in Section 6 of the consultation notice.

- Variations to reflect regional cost differences (the Market Forces Factor). There is no change to this and consequently, no impact to assess.
- Variations to reflect patient complexity (specialist top-up payments). There is also no change to this and consequently, no impact to assess.
- Variations to support prevention of avoidable hospital stays (the marginal rate rule, and the emergency readmissions within 30 days rule). We have assessed the impact of proposed changes to the marginal rate rule in Subsections 4.1 and 4.2, below.
- Variations to support transition to new payment approaches (chemotherapy delivery and external beam radiotherapy, maternity pathway, diagnostic imaging in outpatients, and transitional arrangements for the new best practice tariff (BPT) for primary hip and knee replacements). We have assessed the impact of these in Subsections 4.3 and 4.4, below.

The policy of the following national variations has not changed and we have therefore not conducted any impact assessment on the following:

- Market Forces Factor;
- specialist top-up payments;
- maternity pathway; and
- diagnostic imaging in outpatients.

National variations where there is some proposed change are:

- the marginal rate rule;
- emergency readmissions within 30 days (regarding the need to co-ordinate reinvestment of funds to prevent avoidable readmissions);

- chemotherapy and external beam radiotherapy; and
- the BPT for primary hip and knee replacements.

We examine the impacts of each of these in turn in the remainder of this section.

4.1 Marginal rate rule

The marginal rate rule was introduced in 2010/11. The purpose of the rule is:

- to incentivise lower rates of emergency admissions; and
- to stimulate 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 value for emergency admissions at a provider. A provider is then paid 30% of the national price for any increases in the value of emergency admissions above this baseline. Overall, commissioners must set aside sufficient budget to pay for 100% of emergency admissions. Commissioners are then required to spend the retained 70% on managing the demand for emergency care.

Several stakeholders reported problems with the marginal rate rule, prompting NHS England and Monitor to review the policy[18]. On the basis of this review, we are making significant changes to the rule. These are:

- to provide greater clarity on how and why baselines might be adjusted; and
- to put in place arrangements to ensure that retained money from the application of the marginal rate rule is invested more transparently and effectively.

We assess the impact of these two changes relative to a counterfactual in which the current policy for emergency admissions remains unchanged.

[18] See *Monitor and NHS England's review of the marginal rate rule*

4.1.1 Assessment of impact of providing greater clarity on adjusting baselines

We are aware from anecdotal evidence that there is currently variability in the baselines used by providers and commissioners for measuring emergency admissions. This is to say, some providers have agreed updated baselines and some have not. Because we are not sure of the extent of these updates, this has made it difficult to undertake a quantitative assessment of the proposed change. Hence, our assessment has, by necessity, been qualitative in nature.

The proposal is that baseline adjustments must be made where there have been material changes in the patterns of demand for or supply of emergency care in a local health economy, or when material changes are planned for 2014/15. Baseline values should then be updated to account for material changes that the affected provider cannot directly control. Under the proposals, we would anticipate that:

- more changes to baselines would occur at a larger number of providers relative to the counterfactual case of no policy change; and
- most changes to baselines will be to a higher level than the current baseline.

We assessed the impact of the proposals on the basis of the above assumptions.

From a commissioner perspective, where the policy results in an updating of baselines, commissioners will now have to pay additional funds to acute hospitals. Clearly, the assumed consequence will be that, given fixed budgets, commissioners will have fewer funds to spend on other services.

By contrast, from a provider perspective:

- acute provider finances should be improved where baselines have been adjusted to reflect changes in the level of emergency admissions for reasons outside of their control; but
- non-acute providers may be negatively impacted if the commissioner has to reduce the services they commission from them (that is, in light of the impact on commissioners stated above).

On balance, we believe that this policy will be beneficial to patients. It ensures that providers that have experienced an increase in emergency admissions for reasons outside of their control will be appropriately funded so that the provision of services will be sustained and quality maintained or improved.

4.1.2 Assessment of impact of change to ensure retained money is invested transparently and effectively

The objective of this change is to ensure that commissioners plan effectively to utilise the funds retained by application of the rule, so that the demand for emergency admissions is reduced and also to ensure commissioners budget for 100% of the value of admissions. There are also mechanisms in place to monitor delivery of those plans and evaluate their effectiveness.

From a commissioner perspective, the change is likely to lead to additional administrative costs due to the requirements for preparing, publishing and evaluating their plans. Other stakeholders in the local health economy are also likely to experience an increase in administration costs as a result of participation in the development of the plans.

However, in the longer term, effective management of the demand for emergency care should lead to more health care being provided in a less costly setting, thereby improving the financial position of commissioners. This will be beneficial to patients as, overall, more and better services will be commissioned, and a greater number of patients may be treated in more appropriate settings.

One risk of the proposed changes is that increased oversight of the spend of the savings from the marginal rate rule (spent on the management of demand for emergency care) may in the short term affect the financial position of commissioners who previously used these savings for other purposes[19].

[19] Since 2013/14, commissioners have been required to spend the savings from the marginal rate rule on ‘demand management’. However, we have heard in NHS England and Monitor’s call for evidence that in some places commissioners have used these savings for other purposes, such as supporting funding shortfalls.

From a provider perspective, the scrutiny and rigour provided by demand management plans should mean they are evidence-based, supported by local clinicians, and so ultimately more effective. This means that, although they will potentially incur additional administration costs, all local providers should benefit from being able to focus more on proactive, co-ordinated care rather than reactive emergency care. In turn, this should therefore allow them to shift their resources more towards planned care, on which they have greater opportunity to make higher margins.

Overall, we believe the policies for commissioners to plan carefully to manage the demand for emergency care should be beneficial to patients, as ultimately they should result in a reduction in the number of emergency admissions (instead, these patients will be cared for in more appropriate settings thereby improving the overall quality of care). Also, as emergency admissions tend to be more costly than care in other settings, the reduction in costs resulting from these demand management schemes will allow finite commissioner funds to go further to the benefit of patients.

4.2 Emergency readmissions within 30 days

The 30 day emergency readmissions rule is largely unchanged. There remains the requirement for commissioners to reinvest the money they retain from not paying for emergency readmissions into services that will prevent avoidable readmissions. To ensure transparency and effectiveness of the reinvestment of these funds, commissioners must discuss with providers where this money will be reinvested.

We are now also requiring that reinvestment proposals must be co-ordinated with other commissioning decisions on demand management for emergency care, for example initiatives funded by the retained funds from the marginal rate rule.

This new requirement to co-ordinate the reinvestment of savings will place a small additional administrative burden on both commissioners and providers. However, this co-ordination should lead to better commissioning decisions which reduce the number of emergency readmissions, ultimately to the benefit of patients.

The impact on commissioners will depend on how they are already reinvesting this money. Assuming that they are already following the reinvestment requirements, there should be no additional spend and therefore no budgetary pressures resulting from this additional requirement except for the small additional administrative burden.

Plans to reduce avoidable readmissions should in theory be improved by being aligned to other plans. This should reduce the number of readmissions and therefore reduce lost revenue by providers.

Patients should benefit from avoiding readmission because a readmission may reflect a failure in care delivery.

4.3 Chemotherapy and external beam radiotherapy

Mandatory currencies for chemotherapy delivery and external beam radiotherapy were introduced in the 2012/13 national tariff. National prices for these services were introduced in 2013/14 along with guidance which provided for a staged transition to fully mandated currencies and prices. Commissioners and providers were expected to move at least 50% of the way from their local prices to the national prices during 2013/14.

Providers and commissioners are now expected to use national prices in 2014/15 unless doing so would have an unmanageable financial impact on either provider or commissioner. We therefore assess the impact of this proposed change relative to the counterfactual of not changing the rule from this year's policy.

One issue we have encountered in our assessment is that we do not know exactly how many of the providers and commissioners have moved more than 50% of the way from local to national prices. We have used data from a sample of 19 providers on the actual income generated from these services and conducted an assessment on this sample to assess the financial impacts of moving to national prices.

The income from the chemotherapy and external beam radiotherapy services provided by these providers is around £200 million. This compares to the total estimated value of chemotherapy and external beam radiotherapy services across all providers of around £500 million. The sample therefore represented around 40% of the total public health care market for chemotherapy delivery and external beam radiotherapy.

In our analysis we found that three providers would experience a drop in chemotherapy and radiotherapy income amounting to more than 10% the total if the move to national prices was completed in 2014/15. By contrast, one provider would experience an increase in chemotherapy and radiotherapy income amounting to more than 10% of the total. Table 4-1 below shows the range of changes that we project for the sample provider group.

Table 4-1: Summary of chemotherapy and external beam radiotherapy income changes on sample provider group

	Total change in income		Change in income - chemotherapy		Change in income - radiotherapy	
	£000s	%	£000s	%	£000s	%
Maximum	1,975	17%	1,047	45%	928	10%
Average	-458	-5%	-266	-4%	-192	-2%
Minimum	-5,435	-49%	-3,133	-49%	-3,372	-27%

The table shows that the largest increase in income resulting from the introduction of mandated currencies *and* national prices is £2.0 million, or 17% of that provider's income from chemotherapy and radiotherapy. The largest decrease is £5.4 million, or 49% of that provider's income from chemotherapy and radiotherapy.

It is worth noting that, for eight of the 19 providers in the sample, there was no financial impact as a result of the change to mandating the use of national prices, indicating that they are already using national prices.

If all providers of chemotherapy and external beam radiotherapy income changes were forced to adopt the mandated currencies *and* national prices, our analysis suggests that some providers would be adversely affected. However, the proposed policy takes this into account by explicitly allowing providers not to use the currencies and national prices if doing so would create an unmanageable financial impact. We therefore conclude that the short-term impact of these proposed changes is unlikely to adversely affect patients. In the longer term, we expect the changes to benefit patients by introducing consistency in the way these services are commissioned.

4.4 Variations to best practice tariffs

We have proposed a new primary hip and knee replacement BPT and have assessed the likely impact of this in Section 3 of this document.

As described in Section 4 of the consultation notice, there are some variations allowed to this new BPT whereby commissioners must continue to pay the full amount, even when providers are not meeting all of the best practice payment criteria, as long as the provider can demonstrate either recent improvements, planned improvements, or complex casemix[20]. This has been proposed to allow for transition to the proposed new BPT.

The additional flexibility that this variation affords would ensure that patients do not experience any reduction in quality of service as a result of financial pressure on providers whilst they move toward fulfilling the best practice criteria.

We do not know how many providers will potentially use this variation and have not been able to quantify the impact of it. As a result, it is possible that the quantitative impacts reported in Section 3 of this document in respect of the primary hip and knee BPT may be overstated.

[20] See Subsection 6.4.4 of the consultation notice.

5 Locally determined prices

Section 7 of the consultation notice covers the range of circumstances in which prices for health care services are determined locally rather than nationally. There are two broad categories where this is the case:

- Where services have a national price but prices are determined locally. These arrangements are classified as either:
    - a local variation; or
    - a local modification.
- Where services do not have national prices and prices are set locally.

Section 7 of the consultation notice sets out the rules which providers and commissioners must adhere to when agreeing a local variation or setting prices for services with no national price, and describes Monitor's method for determining local modifications.

In our view, the appropriate counterfactual against which to measure the potential impact of the new framework for locally determined prices is the current PbR system. Under the current system, the PbR guidance sets rules for when providers and commissioners wish to move away from national prices and requires a local price deflator, based on the tariff efficiency and inflation factors, to be used for local price negotiation. We consider a qualitative assessment of the impact of these changes to be most appropriate (see Table 2-1 in Subsection 2.2).

5.1 Principles for locally determined prices

Under the proposed framework for locally determined prices, commissioners and providers should apply three principles when agreeing a local payment approach. These require that:

- local payment approaches must be in the best interests of patients;
- local payment approaches must promote transparency to improve accountability and encourage the sharing of best practice; and
- providers and commissioners must engage constructively with each other when trying to agree local payment approaches.

These principles should be applied throughout the process of agreeing all local variations, modifications or prices.

The principles are largely a formalisation of existing commissioner and provider best practice, and as such should not represent an additional burden on providers and commissioners. However, we hope that the formal requirement to apply the principles will mean best practice is adhered to more consistently across the sector and improve local price-setting in the interests of patients.

5.2 Local variations

Under the proposed rules, commissioners and providers can use local variations to agree adjustments to national prices or currencies. As such, local variations are the main mechanism through which commissioners and providers can design new payment approaches that better support the services required by patients. Under the current payment system, Section 13 (Flexibilities) of the 2013/14 PbR guidance allows commissioners and providers to vary national prices, where these are in the best interests of patients, for example, to support innovation in service delivery and integration of services. As a result, commissioners and providers may already be using alternative payment approaches that better support the services required by patients. In these circumstances, the introduction of local variations may have a limited impact on service delivery models and payment approaches. However, in local health economies where such innovations are not being explored, our proposed principles-based framework should serve to encourage rather than discourage.

As outlined in Section 7 of the consultation notice, for a local variation to be compliant with the national tariff, we propose that commissioners and providers must comply with the following rules:

1) Commissioners and providers must apply the principles for local prices, variations and modifications set out in Subsection 7.1 of the consultation notice when agreeing a local variation.

2) The agreed local variation must be documented in the commissioning contract agreed between the commissioner and provider in relation to the service to which the variation relates[21].

3) The commissioner must use the summary template provided by Monitor when preparing the written statement of the local variation, which must be published as required by the 2012 Act[22].

4) The commissioner must also submit the written statement of the local variation to Monitor.

The impact of 1) has already been addressed above in Subsection 5.1. The impact of the other proposed rules on commissioners, providers and patients is considered in turn.

5.2.1 Commissioner impact

Under the current PbR system, where variations to national prices are agreed, the commissioner is required to keep and publish a written statement of the variations. The PbR guidance also requires that the variation should be documented as part of contract negotiations[23]. The requirements on commissioners are therefore very similar to the current rules and therefore likely to have a minimal impact on commissioners.

The additional reporting requirements we are introducing for 2014/15 are that the commissioner must use a standard template provided by Monitor to prepare the written statement, and that the commissioner must submit the template to Monitor. We believe that providing a standard template should help commissioners to prepare the written statement and does not therefore represent an additional burden on commissioners. Submitting the statement to Monitor does represent an additional requirement, but we consider this to be small and proportionate given the benefit of better understanding of local payment approaches by Monitor to inform future policy.

[21] The NHS Standard Contract is used by commissioners of health care services (other than those commissioned under primary care contracts) and is adaptable for use for a broad range of services and delivery models.

[22] As required by the 2012 Act, section 116(3).

[23] See p.178 of the 2013/14 Payment by Results guidance.

5.2.2 Impact on providers

Rules 2), 3) and 4) on local variations largely apply to commissioners. Rule 2) applies to providers but the PbR guidance already requires that the variation should be documented as part of contract negotiations. We therefore conclude that the impact of the proposed rules on providers, relative to 2013/14, will be minimal.

5.2.3 Impact on patients

The increased use of local variations is expected to have a positive impact on patients in the medium term. In particular, the rules allow greater flexibility in terms of the way that services are delivered; this could facilitate greater integration of care or innovative service delivery models which could have a positive impact on quality of care and patient experience.

Moreover, the requirement on commissioners to submit details of local variations to Monitor should accelerate sharing of commissioning best practice. As this body of data grows, it should lead to better commissioning decisions being made and to the spread of best practice commissioning. Ultimately we expect this to feed through to better quality services to patients.

5.3 Local modifications

Local modifications are intended 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.

There are two types of local modifications:

- **Agreements** – where a provider and one or more commissioners agree to increase nationally determined prices for specific services; and
- **Applications** – where a provider is unable to agree an increase to nationally determined prices with one or more commissioners and applies to Monitor to determine whether the price should be increased.

Under the 2012 Act, Monitor is required to publish in the national tariff its method for deciding whether to approve local modification agreements and for determining local modification applications. Under the proposed method, set out in Section 7 of the consultation notice, local modifications can be used to increase the prices paid to a provider where it faces unavoidable, structurally higher costs that make the provision of specific services uneconomic at the nationally determined price.

The June Preliminary impact assessment (which was published alongside Monitor's National 2014/15 Tariff Engagement Document) presented analysis of the potential impact of local modifications on commissioners, providers and patients. This section therefore considers the impact of three policy conditions for local modification applications that have been finalised since this time.

5.3.1 Policy conditions

This impact assessment focuses on three additional conditions that we propose to place on local modifications applications, which could potentially have an impact on the volume and value of local modification applications, and timing of payment. Subsection 7.3.4 of the consultation notice requires that providers applying for a local modification must (among other requirements):

- demonstrate that the services are Commissioner Requested Services (CRS) or, in the case of NHS trusts or other providers who are not licensed, the provider cannot reasonably cease to provide the services. We refer to this in the discussion below as the 'CRS condition'; and
- demonstrate that the provider has a deficit equal to or greater than 4% of revenues at an organisation level in the previous financial year (i.e. 2013/14 for the 2014/15 national tariff). We refer to this in the discussion below as the 'deficit condition'.

The proposed changes in Subsection 7.3.4 also require that, in most cases, applications will be effective from the start of the following financial year, subject to any changes in national prices. We refer to this in the discussion below as the 'timing of payment condition'.

We assess the impact of these conditions against the counterfactual of all providers being able to make an application for a local modification. In the counterfactual there are no restrictions on the submission of applications, other than the requirement that the services must be uneconomic.

5.3.2 Policy rationale

Local modification applications are required for Commissioner Requested Services (CRS) because a licensed provider is compelled to continue providing CRS under the terms of its licence. The ability of a provider to make a local modification application to Monitor ensures that the provider is fairly paid for the CRS it provides, where a commissioner unreasonably refuses to agree a local modification agreement.

Local modifications applications are not required for non-CRS services, because if the provider believes a non-CRS service is uneconomic, it can cease to provide the service. If a commissioner wishes the service to continue to be provided, it must agree a local modification agreement with the provider.

The deficit condition is intended to take into account possible cross-subsidies, where providers receive a price that is greater than cost for some services with national prices but less than cost for others with national prices. In light of this, our approach is intended to focus Monitor's resources on cases where the refusal of commissioners to agree a local modification is most likely to pose a risk to patients. We consider this to be most likely where the provider is in deficit at an organisational level. Monitor and NHS England may revise this requirement in future if we are satisfied that these issues are properly addressed by other parts of the method for setting prices.

The timing of payment condition was introduced to allow time for commissioning budget allocations to be updated to reflect the modification.

5.3.3 Commissioner impacts

The CRS condition will limit the number of local modification applications, although potentially not significantly in the first year when most of the services provided by NHS foundation trusts are CRS. It may therefore marginally reduce the pressure of local modification applications on commissioner budgets in 2014/15.

The deficit condition will limit the number of local modification applications significantly, which will strongly mitigate the risk of substantial pressure on commissioner budgets.

Further, the timing of payment condition will completely remove the impact of local modification applications on commissioner budgets within the financial year. Commissioners will be able to incorporate any local modification application payments which are awarded into their budget planning for the following year.

5.3.4 Provider impacts

Not allowing local modifications applications for non-CRS services should not have an impact on provider viability, because if the provider believes a non-CRS service is uneconomic, it can cease to provide the service (by definition, ceasing to provide an uneconomic service will not adversely impact a provider's finances).

The deficit threshold may have an impact on provider viability and increase financial risk on providers, in cases where a commissioner refuses to agree a local modification for an uneconomic service but where the provider's deficit is below 4%. However, other mechanisms exist within the system, including Monitor's continuity of services framework, to protect patients in cases of provider financial distress.

The timing of payment condition may also have an impact on provider viability in the short term, as providers who are successful in their local modification application will not receive additional funding in year. However, again, other mechanisms exist within the system to protect patients in the event of financial distress of providers.

5.3.5 Patient impacts

In aggregate, placing restrictions on the submission of local modification applications will have the effect of reducing the risk of significant pressure on commissioner budgets, but at the same time, increasing financial risk to providers. However, the policy is designed to concentrate sector resources on cases where the refusal of commissioners to agree a local modification is most likely to pose a risk to patients.

5.4 Services without a national price

For many NHS services, there are no national prices. Some of these services have nationally specified currencies, but others do not. In both cases, commissioners and providers must work together to set prices for these services. The 2012 Act allows NHS England and Monitor to set rules for local price-setting for such services. Section 7 of the consultation notice sets out the rules that we propose for local price-setting. These include both general rules and rules specific to particular types of services. The specific rules cover the following services:

- Acute services with no national price.
- Mental health services.
- Ambulance and transport services.
- Primary care.
- Community care.

We first address the impact of the general rules and then consider the service-specific rules.

5.4.1 General rules for local price-setting

Rule 1 requires that providers and commissioners must apply three core principles (set out in Subsection 7.1 of the consultation notice) when agreeing prices for services without a national price. The impact of the requirement to apply the principles is discussed above in Subsection 5.1.

Rule 2 requires that commissioners and providers use the cost uplift factors and efficiency requirement in the 2014/15 national tariff [24] when setting local prices for services without a national price for 2014/15, if those services had locally agreed prices in 2013/14. This requirement was part of the previous PbR framework and will therefore have no impact in 2014/15 relative to 2013/14.

Rule 3 requires commissioners and providers to use the national currencies as the basis for local price-setting for the services covered by those national currencies, unless an alternative payment approach is agreed in accordance with Rule 4. Rule 3 also requires providers to submit details of the agreed unit prices for services with a national currency to Monitor.

The use of national currencies was mandatory under the previous PbR framework and this element of Rule 3 will therefore have no impact in 2014/15 relative to 2013/14. The requirement to submit details of agreed unit prices is new and will represent an additional reporting burden on providers. However, we have sought to reduce this burden by providing standard templates to facilitate data submission and believe that the additional administrative cost is proportionate given the benefits of collating this price information centrally. Central collection of local prices for services with national currencies will allow Monitor to compare prices for the same services across different providers and could inform our future price-setting.

Rule 4 covers situations where commissioner and provider of that service wish to move away from using the national currency. When doing so, providers and commissioners must document the agreement in the commissioning contract covering the service in question. The commissioner must also maintain and publish a written statement of the agreement, using a summary template provided by Monitor, and submit the template to Monitor.

The impact of Rule 4 is similar to the impact of local variations discussed above.

[24] The proposals are set out in Section 5 of the consultation notice.

5.4.2 Service-specific rules

The service-specific rules covering acute services with no national price, mental health services, ambulance and transport services, primary care and community care incorporate existing PbR guidance into the new regulatory framework. As such, they will have no impact in 2014/15 relative to 2013/14. New mandatory national currencies are discussed in Section 4 of this document.

6 Specific impact assessment tests

The Better Regulation Executive of BIS has published guidelines which recommend that consideration be given to a range of potential impacts which are of particular relevance to regulatory policy, in order to ensure that the "policy development is joined up and that individual policy proposals take account of a number of broad policy objectives". The guidelines list 10 specific tests, covering a broad range of economic, social, environmental and sustainability impacts.

In order to help support a complete impact assessment, we considered each of the impact areas. However, the relevance and proportionality of each of the specific impacts is dependent on the policy change being proposed and the options being considered. Therefore, in this document, we only consider the specific tests insofar as they relate to our impact assessment objectives as laid out in Section 2 above (i.e. quality of service for patients, budget impact for commissioners and financial viability for providers.)

In doing so, we have classified some specific tests as not relevant for further consideration in this context, under the following two conditions:

- there is no clear direct or indirect link between the impact area and pricing of health care services; and
- impacts are relevant to pricing of health care services in general, but given the options being considered and the changes being proposed, the impacts are not likely to be material.

Table 6-1 below lists the specific impact tests and assesses their potential relevance.

Table 6-1: Specific impacts and their relevance

Specific test	Scoping of test	Summary notes
Competition	Medium	• Secondary effects following viability and budgetary impacts • Relates further to patient choice considerations
Health	High	• Considered through the impact on patient quality
Rural proofing	Medium	• Secondary effects following viability and budgetary impacts
Small firms	Medium	
Equalities	Medium	• Assessment of equality on "protected characteristics"
Sustainable development	None (not relevant)	• Impacts unlikely to be significant and specific discussion not required
Wider environment		
Greenhouse emissions		
Human rights		
Justice		

In this section, we cover each of the specific tests set out above, except those which we consider will not be relevant in this context.

Further, we do not consider it appropriate to address the specific test of “health” in this section, since the impact on health is the main subject of this assessment and is therefore covered throughout this document.

Therefore, in the remainder of this section, we address the following tests in turn:

- competition;
- rural proofing;
- small firms; and
- equalities.

6.1 Competition

For the purpose of this impact assessment, we have considered the impact of the proposed changes on competition from a qualitative perspective. Overall, our view is that the impact on competition of the proposed changes will be beneficial.

On the face of it, there are two features of the proposed changes in the consultation notice that are likely to have a beneficial impact on competition. They are:

- on cost uplifts and efficiency, where the overall impact will be to reduce tariff prices by about 1.6%; and
- on locally determined prices, where the new rules will enhance the transparency of contracting between commissioners and providers.

We briefly discuss our reasoning below.

6.1.1 Reductions in national prices

As we have already noted, we have estimated that the overall impact of the proposed changes on cost uplifts and efficiency will be to reduce tariff prices by an average of 1.6%. As is explained in the consultation notice, the approach in deriving this estimate was to reflect the typical competitive pressures that are present in other sectors of the economy, namely upwards pressure on prices because input costs increase, yet downward pressure on prices to reflect the effects of improved efficiency in the provision of goods or services.

Overall, therefore, given the specific features of the publically funded health care sector in England, the approach to deriving the change in the level of prices has been, in effect, to replicate to some degree the competitive effects that are present in most other parts of the economy. In this way we would consider the proposed changes to be an enhancement of competition to the benefit of patients.

Also, as we set out in Section 3 of this document, downward pressure on prices will, everything else being equal, put additional pressure on provider finances. However, a critical assumption in reaching this conclusion was that the volume of services provided by providers will be the same in 2014/15 as in previous years. In practice, however, we would anticipate that providers will try to offset the impact of the tariff reductions on their overall financial performance by competing for higher volumes of patients. They would do this through improving the quality of the services they offer.

Therefore, NHS England and Monitor's view is that downward pressure on prices will encourage greater competition overall as providers seek to offset the reduction in revenue implied by the tariff decrease by attempting to attract greater volumes of patients by improving the quality of the services they provide.

6.1.2 Locally determined prices

NHS England and Monitor's proposed new rules to increase transparency in locally determined prices relative to current arrangements may, at the margin, enhance competition by impacting upon both commissioner and provider behaviours.

First, commissioners, potentially facing additional transparency (and therefore accountability relative to the previous arrangements) might have additional incentives to put services out to tender and/or to consider alternative models of procurement – thereby enhancing competition. Also, over time, as we collect more data on local variations to national prices and currencies, commissioners will be able to benchmark their contracts against those being agreed elsewhere. Again, NHS England and Monitor's view is that this will be beneficial from a competitive perspective.

Second, providers will now have greater awareness of the contractual terms being agreed between other providers and their commissioners. Greater awareness might encourage other providers to seek to enter the market – as they will have a better understanding of what a new provider would need to offer (in terms of cost and quality) to compete with existing providers. This is likely to enhance competition.

6.2 Rural proofing

The rural proofing test is designed to ensure that patients in rural areas will not be discriminated against as a result of the proposed changes for 2014/15.

Below, we describe:

- our overall approach to assessing impacts on rural communities;
- the results of our assessment; and
- our conclusions.

6.2.1 Approach

To identify providers and commissioners in rural areas, we used the Office for National Statistics (ONS) Health Cluster areas. Using a number of different variables, the ONS has grouped CCGs into eight different clusters which share similar characteristics. The relevant cluster for this analysis is the "Coastal and Countryside" cluster. We matched the CCGs in this cluster to their providers and classified any provider which received over half of its revenue from a "Coastal and Countryside" CCG as a rural/coastal provider. This process identified 17 rural/coastal providers. We added a further two providers that are located in rural areas, by matching their postcodes with the ONS database classification of rural and urban areas. We therefore identified a list of 19 rural/coastal providers.

This, in our view, is a proxy for assessing the impact on patients in rural areas. Naturally, there will be a significant number of patients in rural areas that do not use these providers and over time, we will seek to develop and enhance our impact assessment approach to examine this.

Once we identified these 19 rural/coastal providers, we applied the same financial viability tests as per our impact assessment on national prices (as described in Section 3 of this document). These tests are:

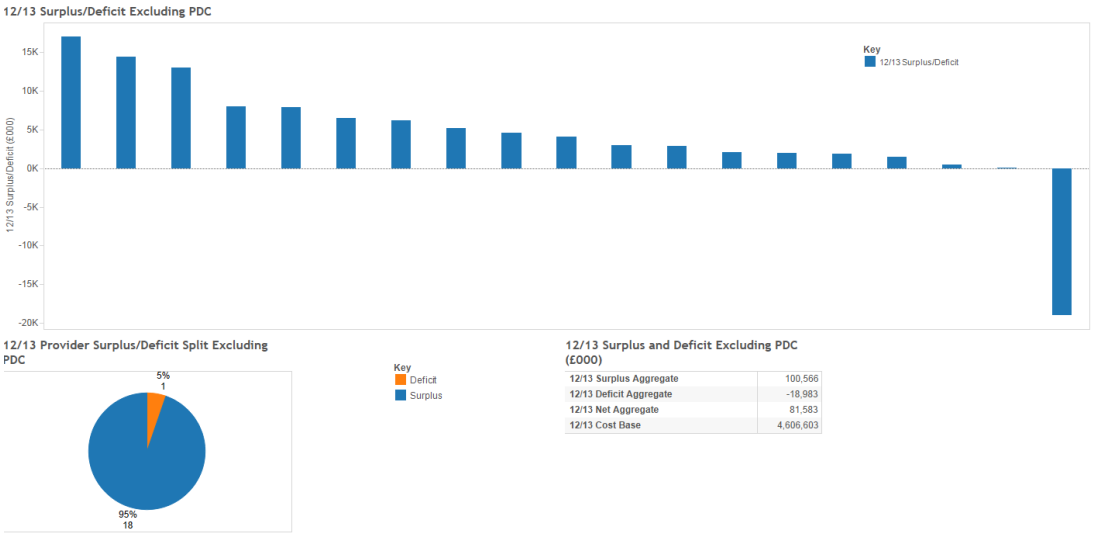
- normalised surplus/deficit;
- normalised surplus/deficit with cash and cash equivalents;
- liquidity days; and
- Capital Service Capacity.

The results are presented in the following subsection.

6.2.2 Results of financial tests on providers in rural/coastal locations

Figure 6-1 below shows that each provider, bar one, was in surplus according to the figures they reported in the FIMS/FTC submissions for the 2012/13 financial year.

Figure 6-1: Normalised rural and coastal provider surpluses/deficits 2012/13



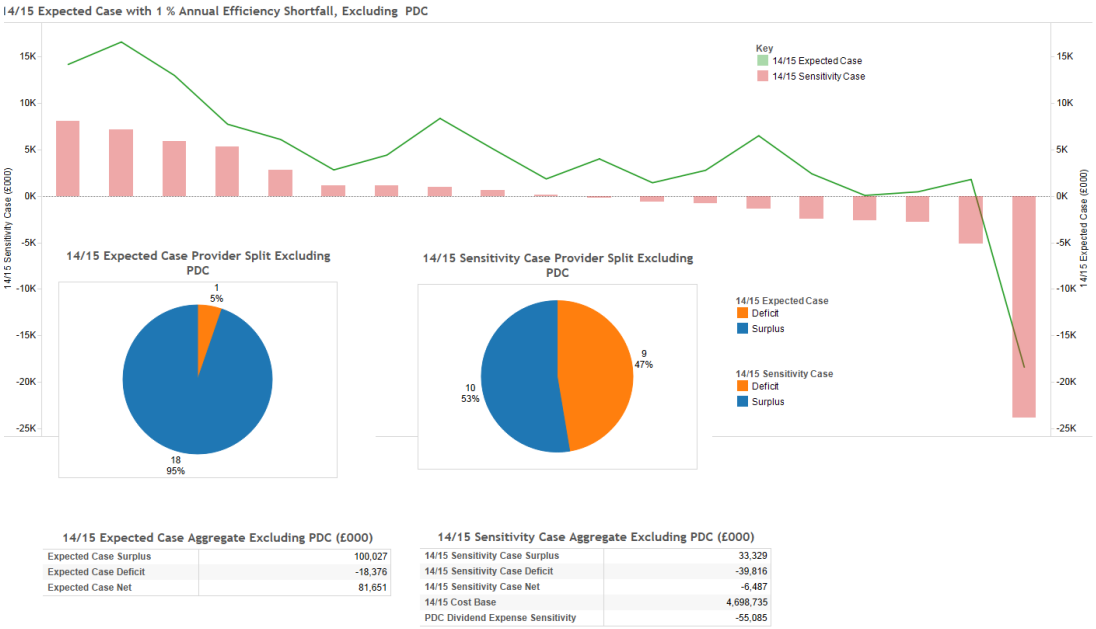
Consistent with the analysis described in Section 2 of this document, we assessed:

- first, how the surpluses and deficits of rural/coastal providers are likely to change over the two years to 2014/15, assuming that income and costs will both decline by a net 1.6% each year (i.e. the overall reduction in prices each year); and
- second, the impact on surpluses and deficits if these providers do not achieve their efficiency requirements by one percentage point each year (the sensitivity scenario).

We found that if all 19 providers missed their efficiency requirements by one percentage point (the sensitivity scenario), then eight rural/coastal providers will move from surplus to deficit. The one provider starting in deficit in 2012/13 will maintain this position under this scenario.

The pattern, similar to the overall provider picture as described in Section 3, is illustrated in Figure 6-2 below.

Figure 6-2: Rural and coastal provider surpluses/deficits 2014/15 – expected and with annual one percentage point efficiency shortfall



14/15 Expected Case Aggregate Excluding PDC (£000)

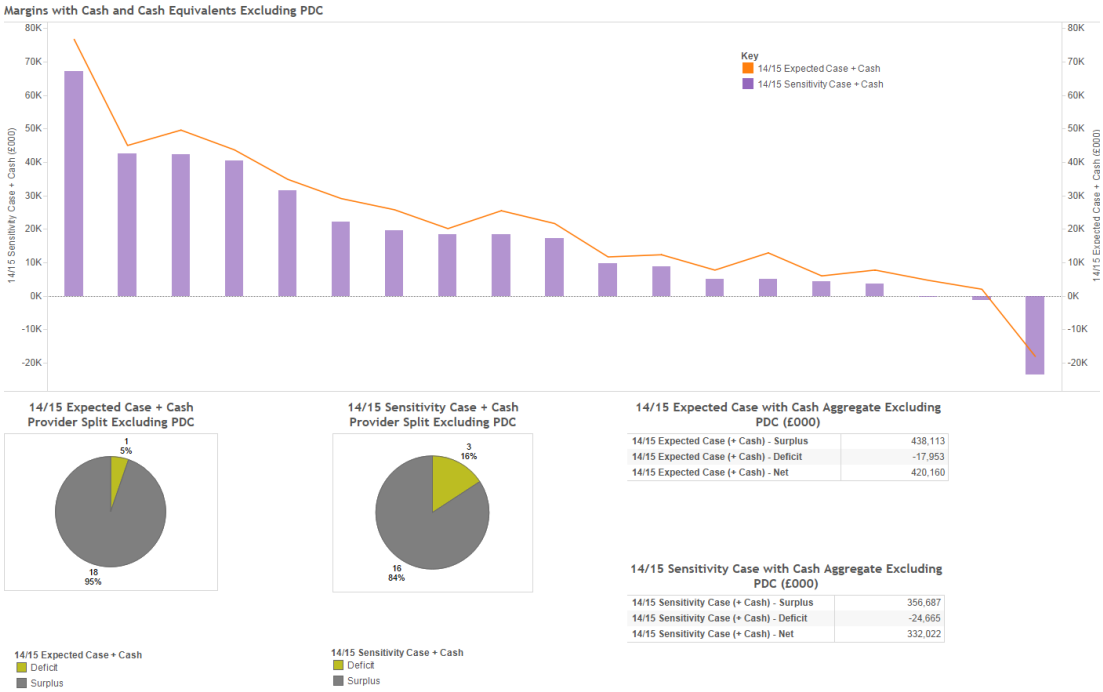
Expected Case Surplus	100,027
Expected Case Deficit	-18,376
Expected Case Net	81,651

14/15 Sensitivity Case Aggregate Excluding PDC (£000)

14/15 Sensitivity Case Surplus	33,329
14/15 Sensitivity Case Deficit	-39,816
14/15 Sensitivity Case Net	-6,487
14/15 Cost Base	4,698,735
PDC Dividend Expense Sensitivity	-55,085

Running the two scenarios above but adding cash and cash equivalents to the normalised surplus deficit positions shows that, like the overall provider picture, cash and cash equivalents cushions the impact of a drop in income and a relative increase in costs (in the sensitivity scenario). Once cash and cash equivalents are added to the surplus/deficit position, only two rural/coastal providers move from a surplus to a very small deficit position, as shown in Figure 6-3 below.

Figure 6-3: Rural and coastal provider surpluses/deficits 2014/15 after cash and cash equivalents



Running the two *Risk assessment framework* tests (liquidity days and Capital Service Capacity) yields similar results to those observed in the full group of providers. Liquidity days deteriorate as costs and income decline.

As with our analysis for all providers generating income from providing tariff services (set out in Section 3.1), the CSC test is sensitive to providers missing their efficiency target, as shown in Figures 6-4 and 6-5 below[25].

[25] The percentage values in these figures do not always sum exactly to 100%. This is caused by rounding errors.

Figure 6-4: Rural and coastal provider liquidity days ratings

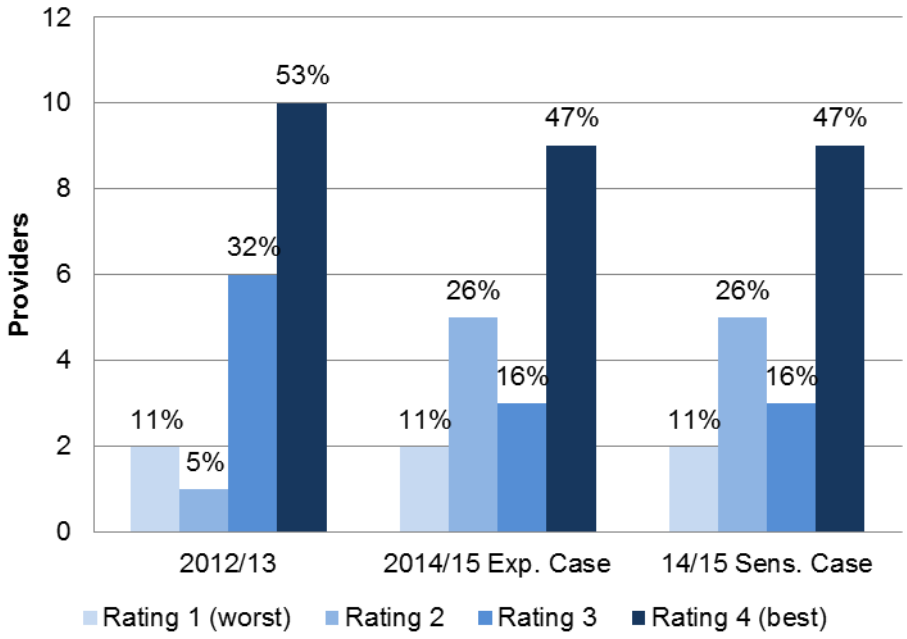
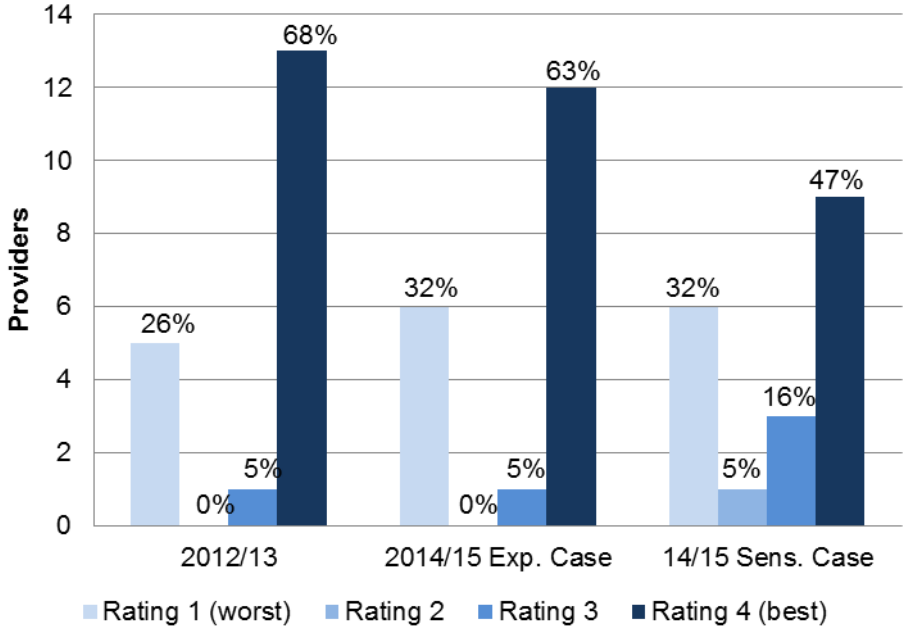


Figure 6-5: Rural and coastal provider Capital Service Capacity ratings



6.2.3 Conclusion on the impact of proposed national tariff on rural and coastal providers

In summary, our analysis shows that the 19 providers we have classified as rural or coastal are not impacted disproportionately (when compared to all NHS trusts and foundation trusts) by the proposed changes for the 2014/15 national tariff.

On the basis of this analysis, we do not believe that rural or coastal providers are adversely impacted by the changes we are proposing.

6.3 Small firms

This test is designed to ensure that small firms will not be discriminated against as a result of the proposed changes for the 2014/15 national tariff.

Below, we describe:

- our overall approach to assessing impacts on small providers;
- the results of our assessment; and
- our conclusions.

6.3.1 Approach

For the purpose of this test, we have defined small firms as public sector health care providers with an operating income of less than, or equal to, £200 million, similar to the definition used by the Health and Social Care Information Centre. To determine operating incomes of each provider, we used financial accounts data either FIMS or FTC submissions for 2012/13.

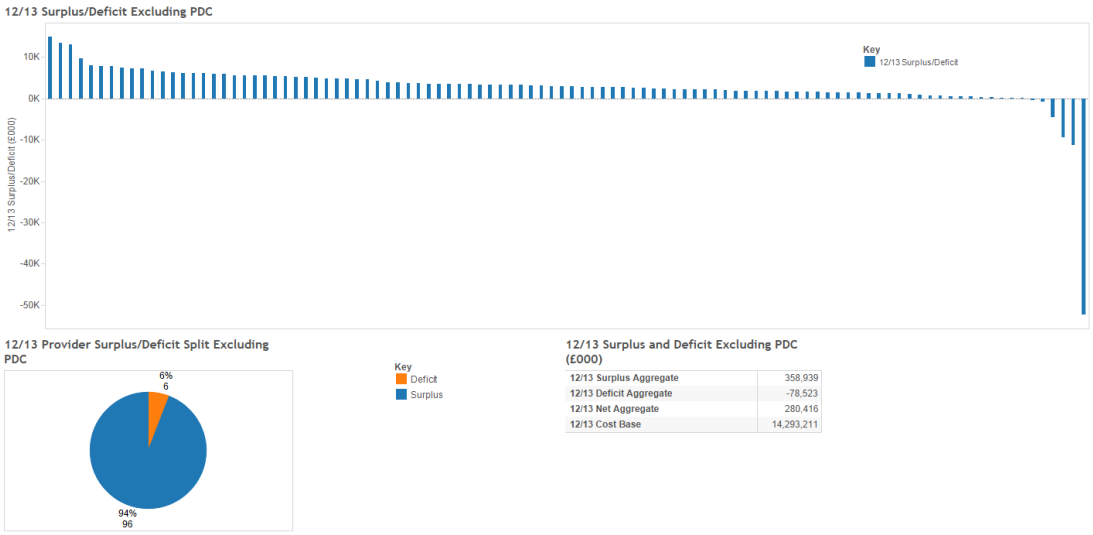
Our definition of a small provider means that 102 out of the 249 providers that generate some income from tariff services are classified as small providers.

We recognise that this approach is not exhaustive. In particular, our overall impact assessment analysis does not include independent providers, which are more likely to fall within our definition of small providers. We are considering how to include such providers in future impact analyses.

6.3.2 Results of financial tests on small providers

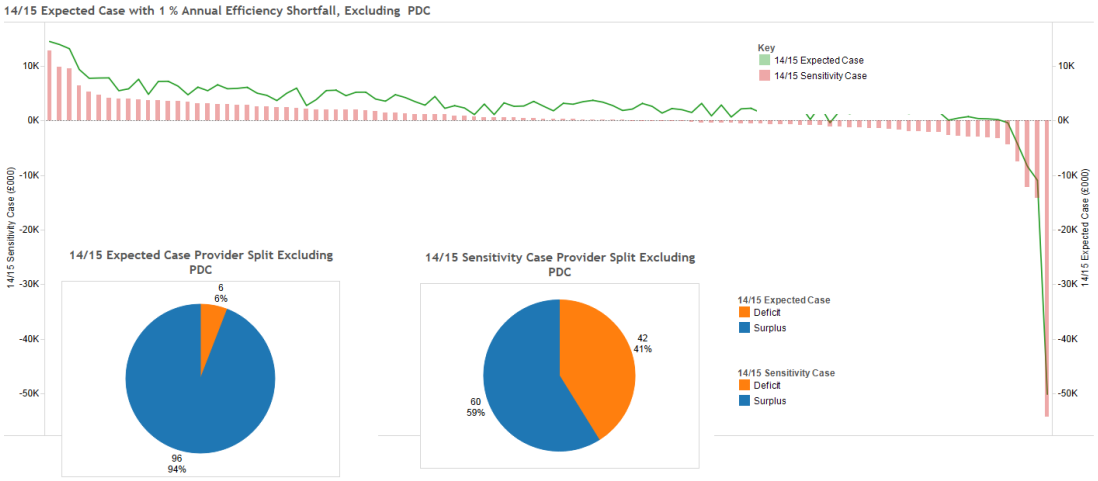
We subjected the small providers to the same four financial viability tests. The results of our assessment are set out below.

Figure 6-6: Normalised small provider surpluses/deficits 2012/13



96 out of the 102 small providers analysed (94%) reported financial data that showed a net surplus after normalising the income and expenses (see Appendix 2 for a description of the steps we took to normalise the reported surplus/deficit results).

Figure 6-7: Small provider surpluses/deficits 2014/15 – expected and with annual one percentage point efficiency shortfall



14/15 Expected Case Aggregate Excluding PDC (£000)

Expected Case Surplus	355,896
Expected Case Deficit	-74,365
Expected Case Net	281,530

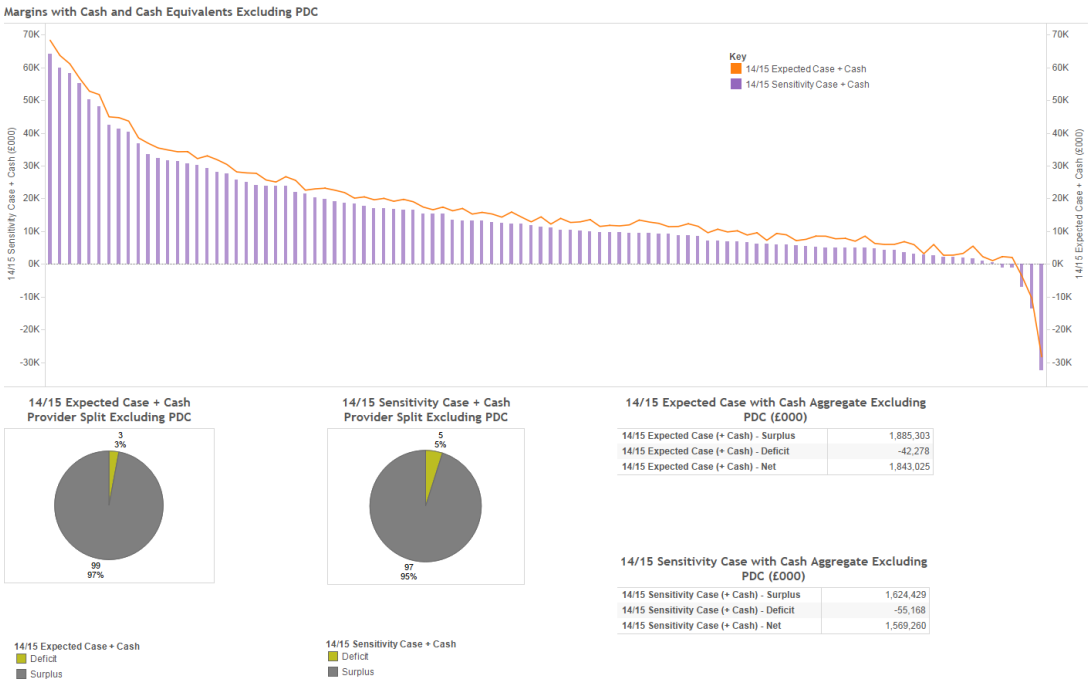
14/15 Sensitivity Case Aggregate Excluding PDC (£000)

14/15 Sensitivity Case Surplus	145,226
14/15 Sensitivity Case Deficit	-137,461
14/15 Sensitivity Case Net	7,765
14/15 Cost Base	14,579,076
PDC Dividend Expense Sensitivity	-155,518

As with the whole provider group, projecting forward the surplus deficit results still suggests that 94% would be in surplus after normalising the reported numbers (and after accounting for annual efficiency improvement requirements). However, running our sensitivity scenario where the small providers do not achieve their efficiency requirements by one percentage point each year results in 41% ending the 2014/15 financial year in deficit, up from 6%.

The small providers have slightly stronger cash and cash equivalent balances than the whole provider group. Figure 6-8 below shows that these cash positions can help absorb some of the short-term impacts of eroding surplus due to costs rising relative to incomes (if efficiency targets are not met).

Figure 6-8: Small provider surpluses/deficits 2014/15 after cash and& cash equivalents



The pattern of deterioration in liquidity days and CSC is very similar to that observed for the whole group of providers, as described in Subsection 3.1.2 of this document. This suggests that the operating cost structure and debt profile of small providers is similar to other providers. Any impacts on the total group are therefore almost identical, from a financial perspective, on this specific group of small providers. This can be seen in the liquidity days and CSC analysis illustrated in Figures 6-9 and 6-10 below[26].

[26] The percentage values in these figures do not always sum exactly to 100%. This is caused by rounding errors.

Figure 6-9: Small provider liquidity days ratings

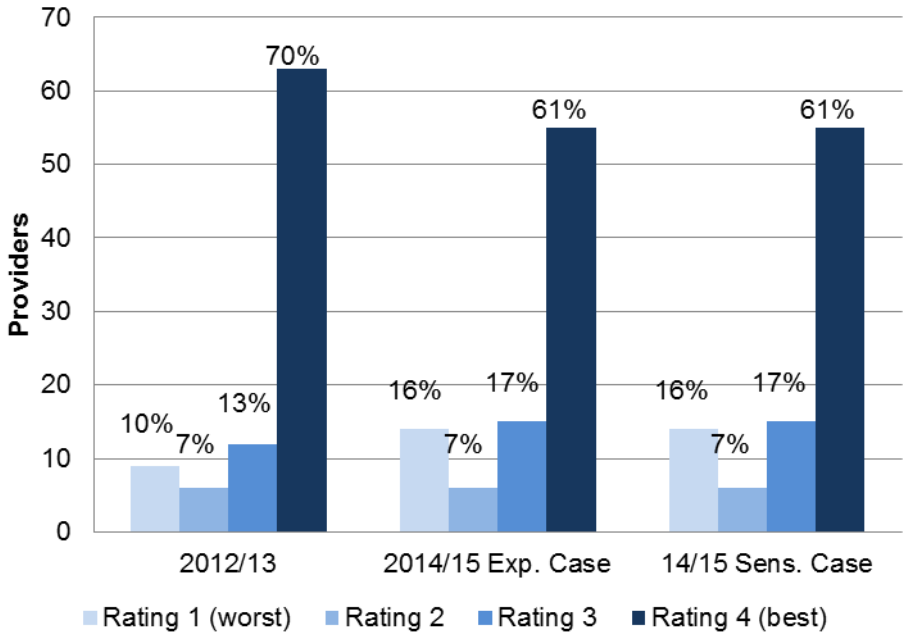
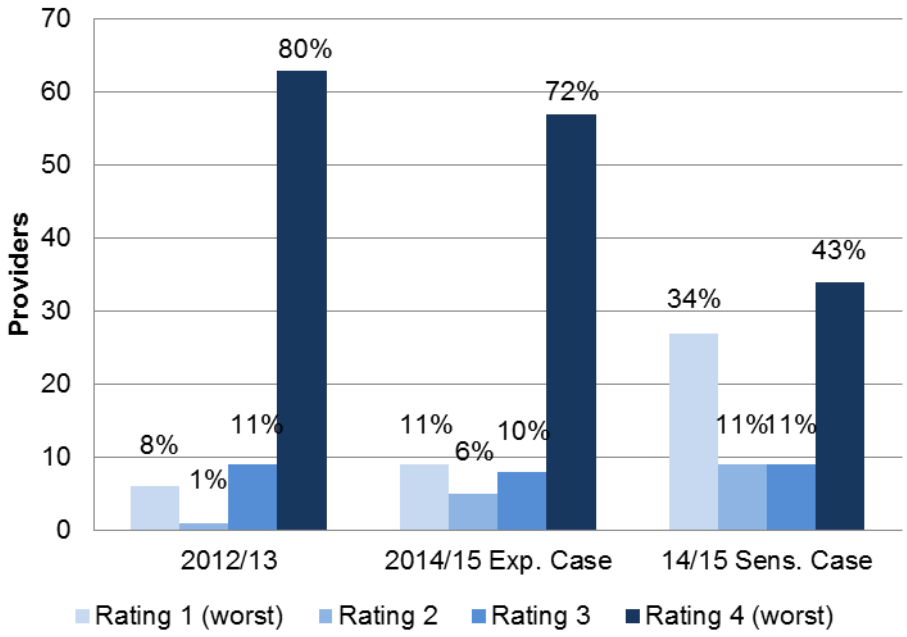


Figure 6-10: Small provider Capital Service Capacity ratings



6.3.3 Conclusion of impact of proposed national tariff on small providers

On the basis of our assessment of the impacts of the proposed national tariff on small providers, there appears to be no material difference between these providers and larger providers. We therefore conclude that the proposed national tariff does not discriminate against smaller providers as defined in this impact assessment.

There are a number of private providers that have not been specifically included in this impact assessment. Given the results of our assessment on the public small providers, we do not believe that other small providers will be adversely impacted by the changes being made to the national tariff.

It follows that patients of smaller providers should not be adversely impacted as a result of the financial pressures on providers, compared to patients of larger health care providers.

6.4 Equalities

The public sector equality duty covers certain 'protected characteristics', and as part of our impact assessment analysis we are obliged to consider the impact of the proposed changes to the national tariff on people sharing these protected characteristics. The protected characteristics are:

- age;
- disability;
- sex;
- gender reassignment;
- pregnancy and maternity; and
- race, sexual orientation, religion or belief.

In this subsection, we describe we have assessed the impact of the proposed changes on people who share the above characteristics. In doing so, we have had regard to previous impact assessments published by the DH, and in particular:

- the impact assessment of the Health and Social Care Bill[27]; and

[27] We have not been able to identify a published impact assessment for the 2012 Act itself.

- the equality impact assessment of the PbR national tariff for 2012/13[28] (hereafter, the 2012/13 EIA).

Given that the proposed currencies and prices for 2014/15 are largely unchanged from the PbR tariff, apart from the adjustments for increased costs and efficiency, we have placed particular reliance on the latter assessment.

We will consider how we can improve the evidence base on the impact of tariff proposals on people who share the protected characteristics in the Equalities Act 2010.

6.4.1 Age

The currency design used in the national tariff (which NHS England and Monitor do not propose to change significantly for 2014/15) reflects, to an extent, the age of the person being treated. In particular, where procedures have additional costs associated with age, the HRGs include an age split, which reflects these costs. The currency design also includes a chapter solely for diseases associated with childhood and neonates (Chapter P), and there are top up payments available for specialised care, including specialised children's services.

According to the 2012/13 EIA, the current system has no adverse impact on people of any age. Therefore we believe that the proposed changes will overall have a positive impact on equality for people of different ages.

6.4.2 Disability

The currency design used in the national tariff (which NHS England and Monitor do not propose to change significantly for 2014/15) differentiates between care provided to a patient with or without complications and comorbidities[29] in order to reflect differences in expected resource use. Complications and comorbidities may be deemed to be major, intermediate or insignificant in terms of requiring additional resources.

ICD codes have been developed in order to recognise patients who have problems related to care-provider dependency (e.g. mobility problems, or a lack of care at home). ICD codes can also reflect mental health issues.

[28] No equality impact assessment was published for the 2013/14 PbR national tariff, so we have instead referred to that published for the 2012/13 PbR national tariff.

[29] Additional conditions that the patient might come into hospital with that increase the complexity of the primary intervention.

According to the 2012/13 EIA, the current system has no adverse impact on disabled people, and we have identified no aspect of the proposed changes which would have an adverse impact on people with disabilities.

6.4.3 Sex

Certain procedures are, by nature, distinctive for male and female patients. For these procedures, the related HRGs are classified by sex. These are shown in Table 6-2 below.

Table 6-2: HRGs classified by sex

LB21Z	Bladder Neck Open Procedures – Male
LB22Z	Laparoscopic Bladder Neck Procedures – Male
LB23Z	Bladder Neck Open Procedures - Female
LB24Z	Laparoscopic Bladder Neck Procedures – Female
LB27Z	Prostate or Bladder Neck Minor Endoscopic Procedure – Male
LB44Z	Non-Operative Interventions of Genital Organs and Perineum – Male

There are also three HRG chapters dedicated to sex-specific procedures. These are shown in Table 6-3 below.

Table 6-3: Sex-specific HRG chapters

Chapter M	Female Reproductive System Disorders and Assisted Reproduction
Chapter N	Obstetrics

The proposed national prices for the 2014/15 national tariff are implicitly based on the average cost of each services reported by NHS providers through the annual reference costs collection, and so reflects the costs incurred in providing sex-specific procedures. According to the 2012/13 EIA, the current system has no adverse impact on people of either sex. Since NHS England and Monitor are not proposing structural price changes in 2014/15, we do not believe that the design of this national tariff payment system will have an adverse impact on people of either sex.

6.4.4 Gender Reassignment

Procedures for gender reassignment attract the relevant HRG price, based on reported costs, and so the payment for these procedures reflects the costs incurred. Given that the 2012/13 EIA did not find any adverse impact on people undergoing gender reassignment, we therefore do not believe that any of the proposed changes will have any adverse impact on those undergoing gender reassignment.

6.4.5 Pregnancy and maternity

In the 13/14 tariff a pathway payment system was introduced for maternity. The gradual introduction of this system will continue in the 2014/15 national tariff.

According to the 2012/13 EIA, the current system has no adverse impact on pregnancy and maternity care, and the continuation of this pathway will have a positive impact on improving equality of care for women experiencing pregnancy and maternity care.

6.4.6 Race, sexual orientation, religion or belief

The national tariff does not distinguish between procedures that are carried out on patients of different race, sexual orientation, religion or belief. Payment is based on reported costs incurred for patients from all backgrounds.

Appendix 1: Monitor's general 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 general duties under Sections 62 and 66 would be secured by implementation of the proposals in the *2014/2015 National Tariff Payment System: A Consultation Notice* , which we refer to below as 'the consultation notice'. This appendix therefore sets out each of the general duties with an explanation of how:

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

Where appropriate, we cross-refer to either the consultation notice or this impact assessment document.

Monitor's general statutory duties are listed in sections 62 and 66 of the 2012 Act. In this subsection, we address each provision in turn.

Section 62 of the 2012 Act

Section 62(1)

(1) The main duty of Monitor in exercising its functions is to protect and promote the interests of people who use health care services by promoting provision of health care services which-

a. is economic, efficient and effective, and

b. maintains or improves the quality of the services.

(2) In carrying out this duty, Monitor must have regard to the likely future demand for health care services[30]*.*

[30] 2012 Act, section 62(2).

Consideration of the interests of patients is fundamental to the proposals in the consultation notice. As indicated in Section 2 of the consultation notice, the payment system should promote value for patients and be a tool for effecting change that benefits patients, in particular by incentivising providers to provide good quality care as efficiently as possible.

Section 62(1)(a) – economic, efficient and effective provision of services

Section 5 of the consultation notice sets out how our proposals for national prices would protect and promote the interests of patients by promoting the provision of services which is economic, efficient and effective. In particular, one of the key principles adopted by NHS England and Monitor when agreeing the proposed method for determining national prices is that prices should reflect efficient costs in so far as is practicable[31]. Also, as discussed in Subsection 5.1.2 of the consultation notice, prices provide a system of signals and incentives that support better health care for a given budget. Prices can incentivise providers to reduce unit costs; and provide information to commissioners to help them make the most effective use of their budgets. Subsection 5.1.2 of the consultation notice also explains how Monitor has approached the balance of short-term and long-term considerations about how the NHS best serves patients' needs.

Monitor's consideration of the interests of patients is central to its proposal to adjust prices in line with its expectations for provider efficiency gains[32]. In particular, Monitor's view was that the efficiency assumption should be set at the highest level that it is reasonable to expect providers to deliver, as this represents best value for patients[33].

Our framework for locally determined prices is also designed to promote economic, efficient and effective provision of health care services, in particular, requiring commissioners and providers to consider cost-effectiveness when agreeing local payment approaches and the consideration of efficiency under the method for local modifications[34].

[31] See Subsection 5.1.1 of the consultation notice.

[32] See Subsection 5.4 of the consultation notice.

[33] See Subsection 5.4.2 of the consultation notice.

[34] See Subsections 7.1.1 and 7.3 of the consultation notice.

Section 62(1)(b) – maintaining or improving quality

As we discussed in Section 5 of the consultation notice, a system of fixed national prices incentivises quality improvements, as providers try to attract patients by offering high quality care. In the same section, we set out how our approach for setting prices and reflecting input cost increases, including the downward adjustment for efficiency, is based on the principle that prices should reflect the costs that a reasonably efficient provider should expect to incur in supplying health care services to the level of quality expected by commissioners[35]. In setting prices, Monitor has had regard to the potential risk to quality of care and patients if prices are set too low[36].

Section 7 of the consultation notice sets out our proposals for locally determined prices. NHS England and Monitor have developed an overarching principles-based framework that we propose should apply to all local prices, variations and modifications. One of these principles is that local payment approaches must be in the best interests of patients. Subsection 7.1.1 develops this, setting out that, throughout the process of agreeing local payment approaches, commissioners and providers should consider, among other things, quality of care, cost effectiveness, innovation, and allocation of risk.

Section 7 also sets out our proposed rules on local variations and local price-setting, which are designed to support and facilitate innovation and service changes to improve care for patients (see Subsection 7.2 and 7.4 of the consultation notice). Our local modifications policy is designed to ensure that health care 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 (see Subsection 7.3).

Section 62(2) – likely future demand

While the *2014/15 National Tariff Payment System* would only cover a period of one year, in setting the proposed efficiency assumption and cost uplift factors, we have had regard to the future financial sustainability of providers.

In addition, the first principle in the framework for local variations, modifications and local price-setting requires commissioners and providers to consider the best interests of patients both now and in the future (see Subsection 7.1.1 of the consultation notice).

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[35] See Subsection 5.1.1 of the consultation notice.

[36] See Subsection 5.1.2 of the consultation notice.

Section 62(3) – anti-competitive behaviour

(3) Monitor must exercise its functions with a view to preventing anti-competitive behaviour in the provision of health care services for the purposes of the NHS which is against the interests of people who use such services[37]*.*

As we explained in Subsection 6.1 of this document, the *2014/15 National Tariff Payment System* places a strong emphasis on transparency. In particular, our framework for locally determined prices is designed to enhance the transparency of local price negotiations. We believe that this will help to prevent anti-competitive behaviour by increasing the accountability and scrutiny of commissioners' procurement decisions. Also, the additional transparency of contractual terms and conditions may, at the margin, attract potential new entrants to the market.

Section 62(4), (5) and (6): integrated care

(4) Monitor must exercise its functions with a view to enabling health care services provided for the purposes of the NHS to be provided in an integrated way where it considers that this would—

a. improve the quality of those services (including the outcomes that are achieved from their provision) or the efficiency of their provision,

b. reduce inequalities between persons with respect to their ability to access those services, or

c. reduce inequalities between persons with respect to the outcomes achieved for them by the provision of those services[38]*.*

(5) Monitor must exercise its functions with a view to enabling the provision of health care services provided for the purposes of the NHS to be integrated with the provision of health-related services or social care services where it considers that this would—

[37] 2012 Act, section 62(3).

[38] 2012 Act, section 62(4).

a. improve the quality of those health care services (including the outcomes that are achieved from their provision) or the efficiency of their provision,
b. reduce inequalities between persons with respect to their ability to access those health care services, or
c. reduce inequalities between persons with respect to the outcomes achieved for them by the provision of those health care services[39].

(6) Monitor must, in carrying out its 2 duties relating to integration, have regard to the way in which NHS England and CCGs carry out their duties as to promoting integration, as set out in the NHS Act 2006[40].

In developing the proposals set out in the consultation notice, Monitor has given specific consideration to integration (see, for example, Subsections 2.1, 3.2 and 3.5 of the consultation notice).

As detailed in Section 7 of the consultation notice, our proposed new rules for varying national prices and currencies are intended to allow providers and commissioners to implement innovative payment approaches to support service re-design and integrated pathways of care. Providers and commissioners can use local variations and local price-setting to invest in integrated NHS services and integrated health and social care (see Subsections 2.3.5, 7.2 and 7.4).

Subsection 7.4.4 details our proposals for payment rules for mental health services. One of the driving principles behind our mental health payment rules, including the cluster currencies, is to facilitate improvement in the integration of different mental health services.

In addition, our proposals for the Marginal Rate Rule (one of the national variations – see Subsection 6.3.1 of the consultation notice) are designed to ensure that the 'retained' funds from the application of the marginal rate rule are invested transparently and effectively in appropriate demand management and improved discharge schemes. Part of this should involve investment in improved coordination of services to reduce avoidable emergency admissions.

[39] 2012 Act, section 62(5).

[40] 2012 Act, section 62(6)

Section 62(7): decision-making

> *(7) Monitor must secure that people who use health care services, and other members of the public, are involved to an appropriate degree in decisions that Monitor makes about the exercise of its functions (other than decisions it makes about the exercise of its functions in a particular case)*[41]*.*

As part of the stakeholder engagement process on the *Tariff Engagement Document*, we invited over 30 patient representative and condition representative groups to offer feedback. The full list of groups is available in Annex 1B of the consultation notice. These groups provided feedback on a number of major issues, including on our "rollover" approach for national prices (that is, using 2013/14 prices as the starting point for the 2014/15 prices). The views submitted during this process have been considered by Monitor, and our responses to the major themes of feedback are also set out in Annex 1B of the consultation notice. In addition, we are publishing a patient leaflet, explaining our proposals (and their context) in clear and simple English.

Section 62(8): 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 NHS Act 2006), and*
> *b. the protection or improvement of public health*[42]*.*

[41] 2012 Act, section 62(7).

[42] 2012 Act, section 62(8).

In developing our proposals, Monitor has gone through an extensive process of policy assurance. All proposals were approved by the Monitor-NHS England Joint Pricing Executive (JPE), whose membership includes NHS England's Director for Acute Episodes of Care (specialising in trauma surgery). We also consulted a Clinical Advisory Panel in the process of developing our changes to currencies from the 2012/13 PbR system. This panel comprised members from each of the Royal Colleges.

The views of a number of bodies with relevant professional expertise were also sought as part of our informal stakeholder engagement over the summer (see Annex 1B of the consultation notice for further details).

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

> *Monitor must exercise its functions in a manner consistent with the performance by the Secretary of State of the duty under section 1(1) of the NHS Act 2006 (duty to promote a comprehensive health service). Secretary of State may issue guidance on this duty (but no such guidance has yet been issued)*[43]*.*

The proposals for the *2014/15 National Tariff Payment System* are consistent with the discharge by the Secretary of State of his duty to continue the promotion of a comprehensive health service, in particular:

a) 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 (e.g. public health services) or an existing payment mechanism (e.g. primary care services).

b) The proposals cover mental health services as well as physical health services.

c) The proposals apply to services for all types of patients, including variations to reflect the differing costs of dealing with more complex patients, e.g. the specialist top-up national variation (see Subsection 6.2 of the consultation notice).

[43] 2012 Act, sections 62(9) and 63.

d) The proposals for the national tariff are specifically designed to support a comprehensive and efficient NHS which provides quality services to patients. For example, it includes proposals for local modifications which ensure that services required by commissioners can continue to be provided if they are not economically viable at the nationally determined price (see Subsection 7.3 of the consultation notice)

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.

Our proposals are also supportive of the NHS Mandate, which is one of the main ways for the Secretary of State to discharge his duty under section 1(1) of the NHS Act 2006:

a) A number of the objectives in the NHS Mandate relate to quality of care and safety. See the explanations above on section 62(1) and below on section 66(1) and (2)(a) for further information.

b) Our proposals for local variations should mean that providers and commissioners have flexibility to innovate and support objectives 6 and 7 of the NHS Mandate ("Free the NHS to innovate" and "The broader role of the NHS in society").

c) Our proposals are supportive of objective 8 of the Mandate ("Finance") in so far as we have had regard to both the viability of providers and the extent to which commissioner budgets will cover their current volume and casemix of services under the proposed national tariff.

d) The proposed method for calculating prices for 2014/15 includes an uplift for “service development” which will reflect the additional costs to providers or major initiatives that are in NHS England’s mandate (see Subsection 5.3.4 of the consultation notice).

e) The current mandate objective relating to mental health has been considered specifically in relation to the proposals for local price-setting using mental health “clusters” (see Subsection 7.4.3 of the consultation notice).

Section 62(10): non-discrimination between providers

(10) Monitor must not exercise its functions for the purpose of causing a variation in the proportion of health care services provided for the

purposes of the NHS that is provided by persons of a particular description if that description is by reference to—

c. whether the persons in question are in the public or (as the case may be) private sector, or

d. some other aspect of their status[44]*.*

Our proposals apply equally to all providers of NHS health care services, whether public or private sector. Our financial impact analysis has included both NHS foundation trusts and NHS trusts. We have not been able to include the private sector in our quantitative impact assessment because of a lack of detailed accounting data from private sector providers.

Section 66 of the 2012 Act

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

(1) In exercising its functions, Monitor must have regard, in particular, to the need to maintain the safety of people who use health care services[45]*.*

The impact assessment has examined the impact of our proposals on patients. Without quantitative evidence of how changes to the *2014/15 National Tariff Payment System* will affect safety, we have only been able to consider this qualitatively.

As set out in Subsection 5.1.1 of the consultation notice, Monitor has applied the approach that prices should reflect the costs that a reasonably efficient provider should expect to incur in supplying health care services to the level of quality expected by commissioners. Monitor has also had regard to the potential risks if prices are set too low[46].

Section 66(2): matters to have regard to

(2) Monitor must, in exercising its functions, also have regard to the following matters in so far as they are consistent with the need to maintain safety of people who use health care services[47]*—*

[44] 2012 Act, section 62(10).

[45] 2012 act, section 66(1).

[46] See Subsection 5.1.2 of the consultation notice.

[47] 2012 Act, section 66(2).

a) *the desirability of securing **continuous improvement in the quality** of health care services provided for the purposes of the NHS and in the efficiency of their provision,*

As we explained in Section 5 of the consultation notice, a system of fixed national prices incentivises quality improvements, as providers try to attract patients by offering high quality care. In the same section, we explain that our approach for setting prices and reflecting input cost increases, including the downward adjustment for efficiency, is based on the principle that prices should reflect the costs that a reasonably efficient provider should expect to incur in supplying health care services to the level of quality expected by commissioners.

As part of our discussion of principles for determining national prices, we note the risk to the long-term interests of patients if prices are set too low (for example, providers may not be adequately compensated for the services they provide, potentially leading to withdrawal of services, compromise on service quality, and/or under-investment in the future delivery of services)[48]. We have had regard to this risk when considering, for example, the appropriate level of the efficiency assumption.

Our changes to the best practice tariffs (BPTs) are also designed to improve quality of care (see Subsection 4.4.3).

NHS England and Monitor have developed an overarching principles-based framework that we propose should apply to all local prices, variations and modifications. Our proposals for locally determined prices are set out Section 7 of the consultation notice. One of these principles is that local payment approaches must be in the best interests of patients. Subsection 7.1.1 develops this, setting out that, throughout the process of agreeing local payment approaches, commissioners and providers should consider, among other things, quality of care, cost effectiveness, innovation, and allocation of risk.

b) *the need for commissioners of health care services for the purposes of the NHS to ensure that the provision of access to the services for those purposes operates fairly,*

[48] See Subsection 5.1.2 of the consultation notice.

c) *the need for commissioners of health care services for the purposes of the NHS to ensure that people who require health care services for those purposes are provided with access to them,*

d) *the need for commissioners of health care services for the purposes of the NHS to make the best use of resources when doing so,*

A key aim of NHS England and Monitor is to set prices that encourage better patient care within the budget available[49]. In deciding on our proposals for the national tariff, we assume that price signals help commissioners to allocate their budgets to deliver the best mix of services for their local health economy and prioritise fair access. The proposals recognise that commissioners have limited budgets, while also having a duty to secure services for their local population.

Our proposed "rollover" approach for prices also reflects consideration of the position of commissioners (see, for example, the fourth paragraph of the Executive Summary of the consultation notice).

Our proposals for provider efficiency also recognise the need for providers to continue to make efficiency improvements, which helps commissioners to make best use of their limited resources[50]. We have set the efficiency assumption this year at, in our judgement, the highest level that it is reasonable to expect providers to deliver, because this represents best value for patients.

Our proposals for local modifications seek 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.

We have also assessed the budget impact for commissioners of our changes. Compared with leaving prices unchanged, we expect that commissioners will have more spending power under our national price proposals. This will allow commissioners some flexibility to buy additional services, more complex services and/or higher quality services.

[49] See Subsection 5.1 of the consultation notice.

[50] See Subsection 5.4 of the consultation notice.

Finally, it should be noted that the proposals in the national tariff have all been agreed with NHS England, which is a commissioner of many NHS services, and is also responsible for the allocation of the NHS budget to clinical commissioning groups and for monitoring their performance. NHS England has necessarily played considerations relevant to commissioners into the process of developing these proposals.

> *e) the desirability of persons who provide health care services for the purposes of the NHS co-operating with each other in order to improve the quality of health care services provided for those purposes,*

Our proposed rules for local variations and local price-setting (see Subsection 7.2 and 7.4) are designed to enable providers to co-operate to deliver integrated care for patients. Under our proposals, constructive engagement between commissioners and providers is one of the three principles that must be applied when agreeing local variations, local modifications or local prices (see Subsection 7.1).

> *f) the need to promote research into matters relevant to the NHS by persons who provide health care services for the purposes of the NHS,*
> *g) the need for high standards in the education and training of health care professionals who provide health care services for the purposes of the NHS,*

The proposals in the *2014/15 National Tariff Payment System* do not include any specific changes to promote actively research, education and training, which are funded through other mechanisms outside of the national tariff. However, we are working to fulfil this duty in other areas, for example, working with the Department of Health on how to improve the costing of research, education and training undertaken by healthcare providers.

> *h) where the Secretary of State publishes a document for the purposes of section 13E of the NHS Act 2006 (improvement of quality of services), any guidance published by the Secretary of State on the parts of that document which the Secretary of State considers to be particularly relevant to Monitor's exercise of its functions*[51]*.*

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

[51] 2012 Act, section 66(2)(h).

Appendix 2: Technical description of financial test calculations

In this appendix, we describe the calculation for the financial tests we use in our IA.

Unless otherwise stated, we are using standard accounting definitions.

Normalised margin

In order to represent the underlying difference between a provider's income and expenditure, we need to make some adjustments to remove one-off impacts that might otherwise distort provider operational performance. Application of these adjustments results in a financial metric we can refer to as a 'normalised margin'.

We have defined normalised margin in this impact assessment as:

- operating and non-operating income;
- *less* operating and non-operating expenditure;
- *add back* impairment losses;
- *subtract* impairment reversals;
- *subtract* the gains on transfers by absorption; and
- *add back* losses on transfers by absorption.

Normalised margin with cash and cash equivalents

The normalised margin with cash and cash equivalents uses the same calculations as above, but adds "cash and cash equivalents" from the Statement of Financial Position (SoFP) worksheet in the FTC template or the TRU02 worksheet in the FIMS template.

Liquidity days

Liquidity days is a test defined and used by Monitor as one of the Risk Assessment Framework (RAF) tests applied to foundation trusts[52].

The RAF defines liquidity days as follows:

*(Cash for liquidity purposes * 360) / operating expenses*

Our definition closely follows that used by the RAF.

We define *cash for liquidity purposes* as follows:

- total current assets (+ve)
- *plus* total current liabilities (-ve)
- less inventories (+ve)
- *less* financial assets available for sale (+ve)
- *less* PFI prepayments (+ve)
- *less* non-current assets held for sale (+ve)

We define operating expenses as follows:

- operating expenses within EBITDA

Capital Service Capacity

Capital Service Capacity (CSC) is a test defined and used by Monitor as one of the Risk Assessment Framework (RAF) tests applied to foundation trusts.

Our definition closely follows that used by the RAF.

We define CSC as follows:

- Revenue available for debt service / capital servicing costs

We define *revenue available for debt services* as follows:

- operating revenue (+ve)
- *plus* operating expenses (-ve)

[52] Further details of this and the Capital Service Capacity test can be found in Section 3.2 of Monitor's Risk Assessment Framework

- *plus* non-operating income (+ve)
- *plus* non-operating expenses (-ve)
- *less* impairments/losses (-ve) or reversals (+ve) on PFI
- *less* impairments/losses (-ve) or reversals (+ve) on non-PFI
- *less* PDC expense (-ve)
- *less* depreciation and amortisation (-ve)
- *less* total interest expense (-ve)
- *less* other non-operating expenses (-ve)
- *less* other financial costs (-ve)
- *less* total non-operating income including gains/losses on disposals (+ve)

We define capital servicing costs as follows:

- PDC dividend expense (-ve)
- *plus* interest expense on overdrafts & working capital facility drawdowns & bridging loans (-ve)
- *plus* interest expense on commercial and non-commercial borrowing (-ve)
- *plus* interest expense on PFIs and finance leases (-ve)
- *plus* other finance costs & non-operating PFI costs (-ve)
- *plus* PDC repayments (-ve)
- *plus* loan repayments (-ve)
- *plus* capital element of PFI and other finance lease payments (-ve)

Appendix 3: Glossary

This glossary provides an explanation of a number of terms and expressions used in this document. It is not intended to have any particular legal effect or to be relied on to provide legal definitions.

Readers should always consider the meaning of an expression in its context in the consultation notice and in this document. In addition, where an expression explained here is also used in the 2012 Act, this glossary does not modify or replace the meaning given in the 2012 Act – in such cases, the glossary should be read in conjunction with the 2012 Act (and its Explanatory Notes).

Term	Description
Acute Trust	A legal entity/organisation providing acute care usually in a hospital.
Admitted Patient Care (APC)	A hospital's activity (patient treatment) after a patient has been admitted to a hospital
Ambulance Trust	A legal body responsible for providing ambulance services within a defined geographic area.
Best Practice Tariffs (BPTs)	Tariffs which are designed to encourage providers to deliver best practice care and to reduce variation in the quality of care. There are a range of different best practice tariffs covering a range of different treatments and types of care.
Block contract	Contract that usually involves a fixed sum to purchase healthcare services during a given period.
Capital Service Capacity (CSC)	This is a measure that indicates the ability of a provider of NHS funded services to cover debt servicing charges, both interest and principal repayments. It is one of the key financial tests used by Monitor to assess the financial health of foundation trusts on a quarterly basis.
Casemix	A way of describing and classifying healthcare activity. Patients are grouped according to their diagnoses and the interventions that are carried out.

Term	Description
Clinical Commissioning Groups (CCGs)	CCGs are groups of general practices that are responsible for commissioning health services for their patients and population. They are overseen by NHS England at a national level.
Clinical Negligence Scheme for Trusts (CNST)	CNST, administered by the NHS Litigation Authority, provides an indemnity to members and their employees in respect of clinical negligence claims. It is funded by contributions paid by members' trusts. In the tariff calculation, cost increases associated with CNST payments are targeted at certain prices to take account of cost pressures arising from these contributions.
Commissioners	Commissioners include all organisations that participate in the procurement of services for NHS patients including NHS England, Local Authorities and their authorised agents, Clinical Commissioning Groups (CCGs) and any procurement agency.
Co-morbidities	The presence of one or more disorders (or diseases) in addition to a primary disease or disorder (e.g. patient diagnosed with cancer and diabetes).
Continuity of Service (CoS)	The concept of ensuring that healthcare services can continue to be provided when providers of NHS funded services get into very serious financial difficulty.
Currency	A unit of healthcare activity such as spell, episode or attendance. The currency is the unit of measurement by which a national price is paid.
Earnings Before Interest, Tax, Depreciation and Amortisation (EBITDA)	This is essentially a "clean" view of net income before the effects of financing and accounting policies.
Elective care	Elective care is planned specialist medical care or surgery, usually following referral from a primary or community health professional such as a GP.
Enforcement guidance	Monitor's enforcement guidance explains the action that it can take to enforce compliance with the provider licence and other regulatory obligations on providers.

Term	Description
Excess bed day payment	For patients who for clinical reasons remain in hospital beyond an expected length of stay, there is additional reimbursement known as an excess bed day payment (sometimes referred to as a long stay payment). The payment applies at a daily rate to all HRGs where the length of stay of the spell exceeds a trim point specific to the HRG.
Financial Information Management System (FIMS)	This system is used to capture reported financial data from NHS Trusts. It is like the FTC for foundation trusts.
Finished Consultant Episode (FCE)	An FCE or consultant episode is a completed period of care for a patient requiring a hospital bed, under the care of one consultant within one healthcare provider. If a patient is transferred from one consultant to another, even if this is within the same provider, the episode ends and another one begins.
Foundation Trust	NHS Trusts that have achieved independent legal status or become public benefit corporations. They have unique governance arrangements and are accountable to local people, who can become members and governors. They are free from Government control and are overseen by Monitor.
Foundation Trust Consolidation template (FTC)	This is a template used to capture annual audited and reported financial data from foundation trusts. It is like FIMS for NHS trusts.
Grouper	Software, created by the Health and Social Care Information Centre, (HSCIC) which takes diagnosis and procedure information from patient records to classify it into clinically meaningful groups. The outputs from the grouper are used as activity currencies for costing and pricing.
Healthcare Resource Groups (HRGs)	The currency for the admitted patient care national tariff based on standard groupings of clinically similar treatments that use similar levels of healthcare resource. HRG4 is the current version of the system in use for payment.

Term	Description
Hospital Episode Statistics (HES)	HES is a data warehouse containing details of all admissions, outpatient appointments and A&E attendances at NHS hospitals in England. This data is collected during a patient's treatment at a hospital and is submitted to enable hospitals to be paid for the care they deliver. HES data is designed to enable secondary use, that is use for non-clinical purposes, of this administrative data.
International Classification of Diseases (ICD-10)	The ICD is a medical classification list produced by the World Health Organization (WHO). It codes for diseases, signs and symptoms and is regularly updated. Version 10 is currently in use.
Local modifications	These are intended to ensure that healthcare services can be delivered where required by commissioners, even if the cost of providing these services is higher than the nationally determined prices. There are two types of local modifications: **Agreements:** where a provider and one or more commissioners agree to increase nationally determined prices for specific services; and **Applications:** where a provider is unable to agree an increase to nationally determined prices with one or more commissioners and applies to Monitor to determine whether the price should be increased. In this case, Monitor is required to publish its method for deciding whether to approve local modification agreements and for determining local modification applications.
Local prices	For many NHS services, there are no national prices. Some of these services have nationally specified currencies, but others do not. In both instances commissioners and providers must work together to set prices for these services. The 2012 Act allows Monitor to set rules for local price setting where it believes this is appropriate.

Term	Description
Local variations	Can be used by commissioners and providers to agree adjustments to nationally-determined prices, currencies or payment approaches where it is in the interests of patients to support a different mix of services or delivery model. This includes cases where services with or without national prices, are bundled or where care is delivered in new settings or where there is use of innovative clinical practices or arrangements to change the allocation of financial risk.
Marginal rate rule (for emergency admissions)	The rule requires that a provider receives payment at 30% of the tariff price for all emergency activity above the baseline in 2008/09. The marginal rate is calculated at a contract level using as a baseline the tariff income value calculated by applying the current tariff level to 2008/09 emergency admissions activity. Commissioners are required to invest the remaining 70% of the tariff income in demand management schemes which prevent inappropriate hospital admissions by improving patient care outside of hospital.
Market Forces Factor (MFF)	An index used in tariff payment and commissioner allocations to estimate the unavoidable regional cost differences of providing healthcare. Each NHS organisation receives an individual MFF value, used to establish the level of unavoidable regional costs they face relative to other NHS organisations.
Monitor	Monitor is the sector regulator of NHS funded health care services. Under the Health and Social Care 2012 Act its main duty is to protect and promote the interests of patients. The Act also gave Monitor and NHS England joint responsibility for the NHS payment system with NHS England specifying the services to be priced and Monitor designing and applying the methodology for pricing them.
NHS England (NHSE)	NHS England oversees the budget, planning, delivery and day-to-day operation of the NHS in England as set out in the Health and Social Care Act 2012.
NHS Litigation Authority (NHSLA)	Administers the Clinical Negligence Scheme for Trusts (CNST)

Term	Description
Specialised Services (formerly NHS Specialised Services)	Specialised services are those provided in relatively few hospitals, accessed by comparatively small numbers of patients but with catchment populations of more than one million. These services tend to be located in specialist hospital trusts that can recruit staff with the appropriate expertise and enable them to develop their skills. Responsibility for commissioning these services now lies with NHS England.
National variations	Adjustment of national prices determined at a national level, reflecting a range of factors such as complexity of treatment or regional cost differences.
Non-elective care	Medical care or surgery that is unplanned (e.g. emergency hospital admission).
Office of National Statistics (ONS)	This is the UK's largest independent producer of official statistics and is the recognised national statistical institute for the UK.
Pathway payments	Single payments that cover a bundle of services that may be provided by a number of providers covering a whole pathway of care for a patient.
Patient-level costing	Patient-level costing is the system to measure the hospital resources used by individual patients.
Patient-level costs	These are calculated by tracing resources actually used by a patient and the associated costs in providing a service.
Patient Level Information and Costing Systems (PLICS)	Systems that support the collection and recording of patient level costs.
Patient Reported Outcome Measures (PROMS)	These allow the NHS to measure and improve the quality of treatments and care that patients receive. Patients are asked about their health and quality of life before they have an operation, and about their health and effectiveness of the operation afterwards.
Payment by Results (PbR)	Payment by Results was an approach to paying providers on the basis of activity undertaken, in accordance with national rules and a national tariff. This term being phased out as the national tariff gives Monitor and NHS England a broader set of responsibilities for the payment system.

Term	Description
Primary care	Services provided by family doctors, dentists, pharmacists, optometrists and ophthalmic medical practitioners, together with district nurses and health visitors.
QUIPP	The Quality, Innovation, Productivity and Prevention (QIPP) programme is a large scale programme developed by the Department of Health to drive forward quality improvements in NHS care at the same time as making significant efficiency savings.
Reference Costs	The collection of detailed costs to the NHS of providing services in a given financial year. NHS health care providers are required to submit Reference Costs data to the Department of Health. The costs are published on an annual basis.
Risk Assessment Framework (RAF)	This is Monitor's approach to overseeing NHS foundation trusts' compliance with the governance and continuity of services requirements of their provider licence.
Secondary care	Hospital or specialist care to which a patient is referred by their GP.
Secondary Uses Service (SUS)	The Secondary Uses Service (SUS) is a single comprehensive repository for healthcare data in England which enables a range of reporting and analyses to support the delivery of NHS healthcare services.
Service Development	The service development element of the tariff uplift factor reflects the additional costs to providers of meeting the requirements set out in the NHS England Mandate.
Short Stay Emergency (SSEM)	An emergency admission involving a short period of stay in hospital.
Specialist top-up	Top-up that is applied to specialist activity (defined by the Specialised Services National Definition Sets).
Spell	The period from the date that a patient is admitted into hospital until the date they are discharged, which may contain one or more episodes of treatment.

Term	Description
Stakeholders	The term stakeholders covers all parties operating within the system, and groups within those stakeholders, including clinicians and managers. It also includes patients and members of the public.
Statement of Financial Position (SoFP)	This is one of the worksheets in the FTC template containing financial information for foundation trusts. It contains similar information to a financial balance sheet.
Top Up Payments	Top-up payments are applied as a percentage increase to the tariff price. They are designed to recognise that patients who receive some types of specialised care may be more expensive than those allocated to the same HRG who do not require specialised care.
Trauma Audit and Research Network (TARN)	This organisation collects and analyses clinical and epidemiological data and to provide a statistical base to support clinical audit to aid the development of trauma services.
Trim point	For each HRG, the trim point is calculated as the upper quartile length of stay for that HRG plus 1.5 times the inter-quartile range of length of stay. After the spell of treatment exceeds this number of days, a provider will receive a payment for each additional day that the patient remains in hospital. This is referred to as an excess bed day payment or a long stay payment.

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Publication code: IRCP 06/13