Monitor

Making the health sector work for patients

2015/16 National Tariff Payment System: Impact assessment framework

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About Monitor

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

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Foreword

We are committed to a robust assessment of the impact that the proposals for the 2015/16 National Tariff Payment System would be likely to have on patients, commissioners and providers of NHS services, or the general public in England.[1]

In response to stakeholder feedback we have updated the draft impact assessment framework that we published for consultation on 25 April 2014 as part of our wider engagement on the methodology for the national tariff. We received more than 50 responses to our questions on the draft impact assessment framework. Most of them supported the proposed framework, with 86% of respondents agreeing with the principles proposed and 67% agreeing with our approach to identifying costs, benefits and risks. They also provided a range of constructive points on how the framework could be improved, including clarifying how we will take into account integrated care and changes to service specifications. The feedback also helped us to make improvements to some of the quantitative metrics we use to support our assessments. We have considered all of the responses we received during the consultation period. Stakeholder feedback is invaluable to us in our aim to help make the health sector work better for patients.

As a result of stakeholder feedback, we have made the following updates to our draft impact assessment framework for the 2015/16 national tariff:

- Our approach to impact assessment (set out in Section 3) now takes into account:
    - non-compliance with, and enforcement of, the national tariff as part of our approach
    - where it is possible to do so, changes in regulations or service specifications as a result of commitments in either the NHS Mandate or new currencies set by NHS England
    - the impact of pricing policies on the delivery of integrated care as part of our assessment of costs, benefits and risks
    - in more detail, the need to analyse the equality impacts of the proposals, so that we comply with our statutory public sector equality duty (PSED).
- Our quantitative modelling approach (set out in Annex A) now includes:
    - a single metric for assessing financial impacts on clinical commissioning groups (CCGs) which measures change in the cost of commissioning services as a result of changes to prices (assuming the volume and mix of services commissioned remains the same)

[1] The Health and Social Care Act (the 2012 Act), section 69.

- consideration of ways to analyse the impact of price changes on NHS England's specialised services expenditure
- a new metric to assess the total change in revenue paid for services with national prices for a particular clinical specialty (as defined by chapters of healthcare resource groups (HRGs), such as vascular system or sub-chapters, such as radiotherapy), assuming the volume and mix of services commissioned remain the same.

1. Introduction

It is good practice to carry out impact assessments for major policy and regulatory decisions. At Monitor, we use impact assessments as a tool to ensure that our decisions support our primary objective: to make the health sector work better for patients. We are also required by law to undertake impact assessments for any proposals that would be likely to have significant impacts on patients, commissioners and providers of NHS services, or the general public in England.[2]

We are committed to decision-making that is informed by robust evidence. We view the integration of impact assessment into our policy development and decision-making process as essential to achieving this goal. Good impact assessments enhance the evidence base for evaluating policies, which in turn allows us to engage more meaningfully with stakeholders. They help us identify the risks and potential unintended consequences of policies before they are implemented, and to take pre-emptive action to mitigate any issues.

We also recognise the limitations of impact assessments and the need for regulators to use discretion where appropriate. Our impact assessments will inform, rather than determine, policy decisions and the extent to which they influence policy will depend on their completeness and robustness. In developing our assessments, we will draw on relevant guidance and the regulatory precedents available, while tailoring the approach to the healthcare sector and the specific requirements of each policy proposal. We recognise that the approach set out in this document can be improved over time, and welcome feedback on how to do this.

We will consider and assess impacts at various stages of policy development, and ensure that the comprehensiveness of the assessment is proportionate to the stage of development. In this document we are focusing on assessments that are specific to the 2015/16 National Tariff Payment System.

Stakeholder feedback and involvement in developing and refining our approach to impact assessment is essential. Providers, commissioners, patient groups and clinicians are well placed to identify the potential costs, benefits and risks of our policy proposals, as well as their likely effects. We hope to draw on the sector's expertise by engaging on our proposals for the 2015/16 national tariff. We anticipate that this will help to shape the impact assessments so they are both relevant to and widely accepted by the sector.

We will publish impact assessments of our policy proposals for the 2015/16 national tariff alongside the statutory consultation notice. We hope that this will enhance the transparency of our decision-making and improve communication with stakeholders,

[2] The 2012 Act, section 69.

helping them become more informed about the potential consequences of the policies we propose.

The rest of this document is structured as follows:

- Section 2 lists the principles we intend to apply to impact assessments of the 2015/16 national tariff
- Section 3 sets out our proposed approach to assessing the impact of policies in the 2015/16 national tariff, and notes the limitations of the approach
- Annex A provides detail on the modelling approach we will use to assess proposed changes to the 2015/16 national tariff.

2. Principles guiding our impact assessments

This section sets out the principles we will use to assess the impact of our policy proposals. Our approach aims to provide a consistent framework for assessing the impact in terms of likely costs, benefits and risks, with patients at the heart of our assessments. We will have regard to general guidance[3] on carrying out impact assessments, as appropriate.[4]

We aim to make our approach to impact assessments for the 2015/16 national tariff :

- **Proportionate:** We will carry out impact assessments that are suited to each policy proposal, and the information available for conducting the assessment.
- **Transparent**: We will strive to make our approach simple to follow and accessible to stakeholders. We will clearly state our assumptions and the limitations of our analysis. We will proactively engage with the sector and, where appropriate, incorporate feedback into our assessments.
- **Evidence-based:** We will use evidence, where available, from policies that have already been implemented to increase our understanding of the likely impacts of new policy proposals. We will seek to evaluate implemented policies and incorporate lessons into future impact assessments.
- **Specific to the policy:** We will focus on the key issues relevant to each policy, segment of care, or group of patients, while also considering broader objectives such as equality and patient choice. Our approach will identify incentives relevant to the policy and the way the policy is likely to affect commissioners, providers and patients (the 'transmission mechanism').[5]
- **Compared to an appropriate baseline:** We will clearly define the baseline against which we assess the impact of policy changes.[6] In most cases, we will compare proposals for 2015/16 to a scenario based on the 2014/15 National Tariff Payment System.
- **Robust to key assumptions:** We will consider how sensitive the results of our impact assessments are to a range of possible scenarios based on reasonable assumptions.

[3] For example: HM Treasury (2003, updated 2011), 'The Green Book - Appraisal and Evaluation in Central Government' and HM Government (2011), 'IA Toolkit: How to do an Impact Assessment'.
[4] Section 69(6) of the 2012 Act requires us to have regard to such general guidance as we consider appropriate, when determining the matters to which the assessment relates.
[5] See Figure 2 for an overview of the transmission mechanism of policy proposals.
[6] This is often referred to as a 'counterfactual'.

In relation to considering the impacts on equality, we will also consider the principles that guide how a public authority complies with the public sector equality duty.[7]

[7] As set out, for example, in guidance from the Equality and Human Rights Commission.

3. Our approach for the 2015/16 national tariff

This section sets out the approach we intend to take for assessing the impacts on commissioners, providers and patients of each policy proposal or set of proposals. It is driven by our main duty to protect and promote the interests of people who use healthcare services by promoting provision of healthcare that is economic, efficient and effective, and which maintains or improves the quality of services.[8] This section also identifies they key limitations of our proposed approach and sets out our approach to equality impacts.

Our impact assessments for the 2015/16 national tariff will focus on the incremental costs and benefits that may result from changes or updates to price-setting policies, as well as potential risks. They will focus on costs, benefits and risks that are likely to occur in 2015/16. There may be longer term impacts, and we will try to take account of them in our assessment, while recognising that there is likely to be more uncertainty around such estimates.

We also recognise that there may be important system-wide impacts, such as impacts on patient choice, competition and integrated care. For example, impacts on a specific provider or commissioner could bring about indirect benefits or costs to a local health economy. By the same token, policies intended to benefit a local health economy directly could then affect individual commissioners or providers. In either case, there may be a consequential impact on patients, which we are interested in understanding. As far as possible, we will aim to identify any system-wide impacts; and although we will not routinely publish impact assessments that identify specific commissioners or providers, we will consider the impact on groups of commissioners, providers and patients.

When included in the NHS Mandate, in new legislation or otherwise specified by NHS England, we will seek to take into account (qualitatively if not quantitatively) implications of new requirements on commissioners and providers. We will work to develop our understanding of where such impacts are likely to occur through our stakeholder engagement.

Our approach to our assessments will have the following stages:

1. **Describing the policy proposal:** We will be clear on the issue(s) that the policy is aiming to address, and its likely transmission mechanism. This includes the economic, social and/or environmental rationale for the policy, and any changes to the incentives on commissioners and providers. We will

[8] The 2012 Act, section 62(1).

identify the patient groups and segments of the healthcare sector targeted by the policy.[9]

2. **Conducting a proportionality test:** We will take account of the scale and materiality of policy proposals, and the information available. We describe our proportionality framework in Section 3.1.

3. **Defining the form of impact assessment:** Based on the type of policy proposal and our proportionality assessment, we will decide whether quantitative or qualitative assessment is appropriate, or a combination of the two.

4. **Identifying the relevant baseline:** We will consider the future conditions that might prevail in the absence of the proposed policy. We will use this as a baseline scenario (counterfactual) against which to compare our proposed policies for 2015/16. Our primary focus will be on incremental impacts. Where appropriate, we will also compare the impacts with those of alternative policy options.

5. **Identifying likely costs, benefits and risks:** We will seek to identify material costs, benefits and risks and attribute them to the relevant parties, as well as system-wide impacts (including impacts on patient choice and competition and on integrated care) where possible. We will assess the implications of policy proposals on economic, social, environmental and sustainability issues that are particularly relevant to regulatory policy.[10] We will also aim to take into account administrative and implementation costs.[11]

6. **Considering interactions with other policies:** We will consider whether the impact of the policy is likely to be affected by existing policies or other policy proposals. We will also present a comprehensive impact assessment of the national tariff in aggregate, where practicable, recognising that overall impacts may differ from the sum of individual impacts. In doing so we will make clear our assumptions about commissioners and providers complying with the national tariff.

The rest of this section provides more information on our proportionality framework, including how we will decide whether to use quantitative or qualitative analysis. We also describe our approach to identifying costs, benefits and risks.

[9] We plan to identify impact across care segments such as urgent and emergency care, planned care, integrated care, specialised and complex care, and mental health and community services.
[10] The Department for Business, Innovation and Skills (BIS) guidelines list ten specific impact tests that are relevant to regulatory decisions. Of those, we consider the following four to be most relevant for our assessments: impact on competition, small firms, rural proofing and equalities.
[11] We will follow the guidelines set out in HM Treasury's 'Green Book'. Administrative costs could include costs associated with familiarisation with administrative requirements, record keeping and reporting, including inspection and enforcement of regulation.

3.1 Our approach to proportionality

Policy proposals may address several different aspects of the payment system, including currencies,[12] national prices, national variations or local payment arrangements (local modifications, local variations and locally agreed prices).[13] In each case, the transmission mechanism and impact of the policy may be different, and the feasibility of conducting a comprehensive impact assessment will also vary.

We will apply the guidelines set out in the government's Impact Assessment Toolkit when conducting proportionality tests. These identify the following key considerations for determining the level of assessment required:

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

3.2 Qualitative and quantitative assessment

We want our assessments to inform the answer to the question 'Is this proposal likely to be in patients' best interests?' through an appropriate use of quantitative and qualitative analysis. We will decide whether policy impact is best assessed quantitatively (for example by modelling the financial impact on providers and commissioners) or qualitatively (for example by identifying the incentives a policy creates for providers and commissioners and how these incentives are likely to affect patient care), or a combination of the two. We will take a pragmatic and proportionate approach, recognising that it may be difficult to quantify some costs and benefits, especially those that directly affect patients.

The level of detail in our analysis may vary as different assessments may require different levels of detail and resources. This is consistent with government's Impact Assessment Toolkit guidelines. Depending on the circumstances we would expect to be able to do some or all of the following:

- identify who will be affected

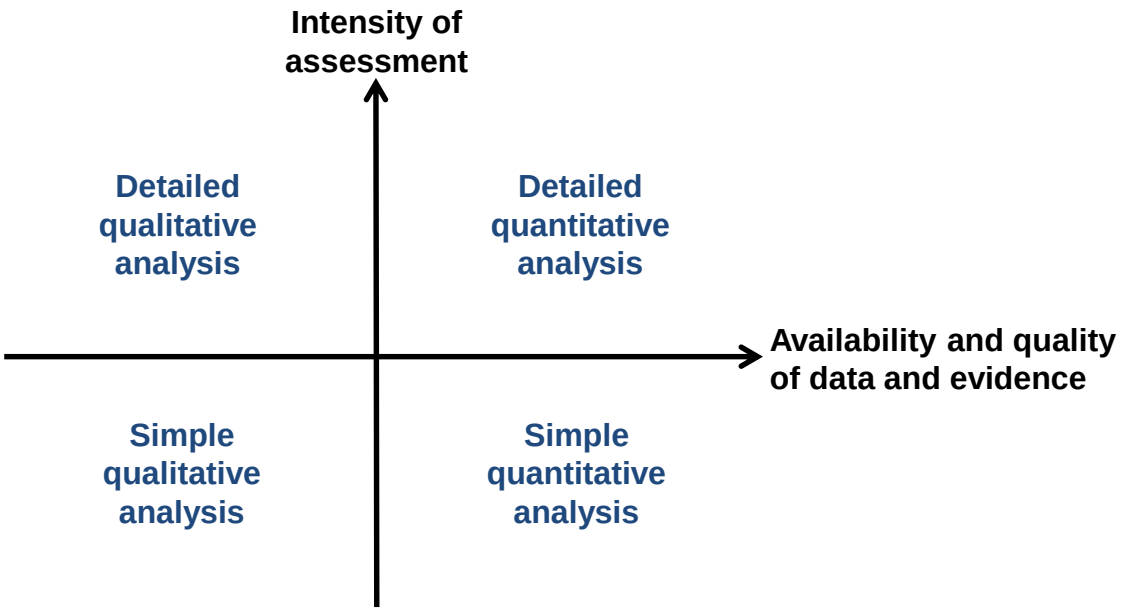
[12] Currencies are used to define the basis for payment for NHS services, as well as being the basis for the collection of information on costs in the form of Reference Costs.
[13] National prices, national variations, and locally determined prices are described in detail in the '2014/15 National Tariff Payment System'.

- describe impacts (direction and order of magnitude)
- quantify impacts where feasible
- make partial valuation of the costs and benefits
- make full monetisation of the costs and benefits.

Our assessments will aim to compare the costs and benefits of the proposal and the baseline scenario (and/or alternative proposals) for affected commissioners, providers or patient groups.

A key determinant of our ability to carry out quantitative assessment is the availability of data. In order to conduct meaningful quantitative analysis we require robust and relevant data, and evidence of how policy changes are transmitted. Where such data are not available, or where we have insufficient evidence to model the impact of the policy, we will carry out qualitative analysis. Figure 1 illustrates the types of assessments we would produce in different circumstances.

Figure 1: Application of the proportionality framework

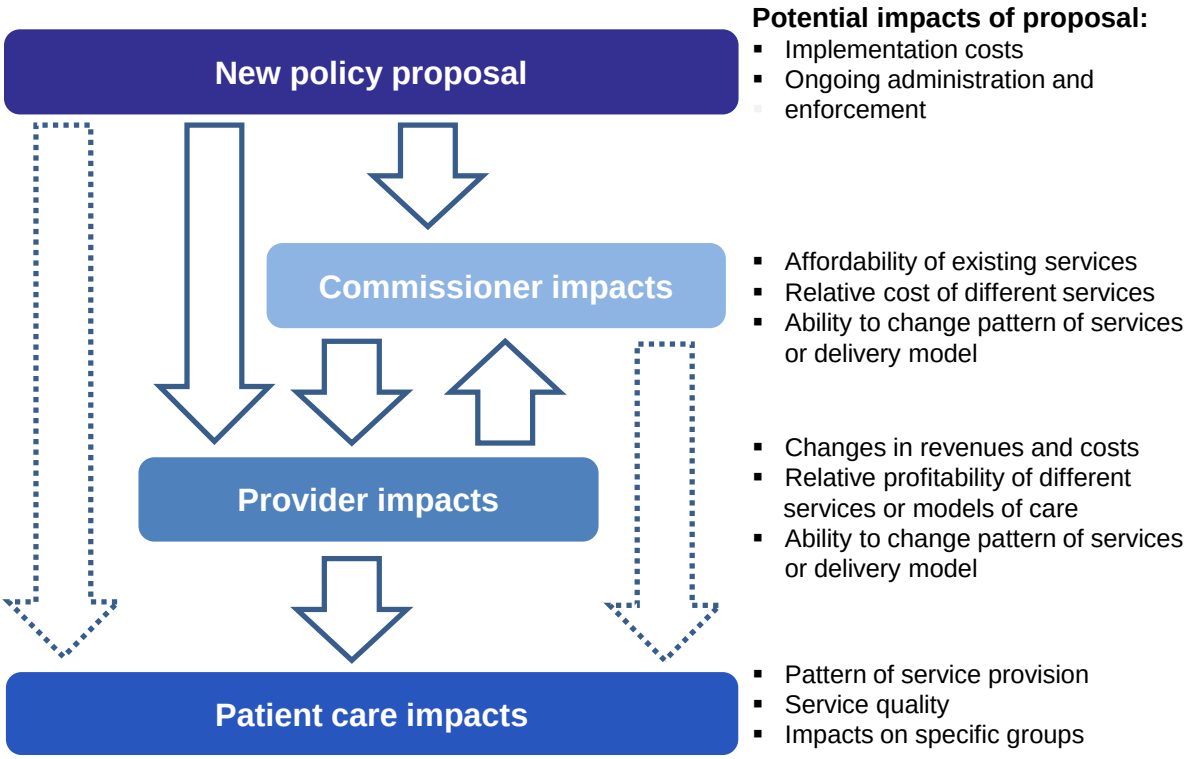


3.3 Identifying costs, benefits and risks

NHS-funded healthcare services are free at the point of delivery for patients so price-setting policies do not manifest themselves directly through financial impact on patients. Instead, our policies affect patients through the incentives and signals they create for providers and commissioners. For example, changing prices may encourage providers to adopt new models of care or commissioners to commission services differently. These changes could affect the care patients receive and the choices available to them (or to clinicians who are responsible for referrals).

One way that we can identify the strength of the incentives created by our policies is by estimating the financial impacts on providers and commissioners. However, this sort of analysis is limited in what it can say about impacts on patients, which are much harder to quantify. To qualitatively assess impacts on patients, we need to understand the transmission mechanisms that link our policies to the things that matter for patients – including the type, quality and location of services available to them. Figure 2 illustrates the main framework we will use to do this.

Figure 2: Overview of the transmission mechanism of policy proposals



We are aware that transmission mechanisms may differ across segments of healthcare, or between policies that provide financial and non-financial incentives. We will aim to reflect such differences in our assessments: it is important that our assessments incorporate possible behavioural responses to new or updated policies by providers, commissions and patients.

As a starting point for our impact assessment, we may consider how the financial positions of providers and commissioners would be affected if they continued to purchase or provide the same healthcare services they have in the past. This will give us an indication of the incentives on providers and commissioners to change their behaviour, which could be an objective of the policy. However, this approach is limited because it does not capture the dynamic way providers and commissioners might respond to changes in the national tariff and what their responses could mean for patients. To address limitation, this sort of 'static' analysis will be supported by wider consideration of the incentives on providers and commissioners created by the

policy proposals. We provide more detail on how we propose to model this type of assessment in Annex A.

We do not currently have a systematic approach for identifying quantitatively the impact of changes to the payment system on patients. However, for the 2015/16 national tariff we plan to use the following measures where they are useful to our assessments:

- We plan to use the Care Quality Commission (CQC) risk rating14 for each provider as an indicator of current quality levels. We intend to pay particular attention to the financial impacts on providers whose quality risk measures are in the bottom quartile compared to the national average.
- We will show how prices change for different types of care (as measured by chapters or sub-chapters of HRGs, such as radiotherapy) and what that would mean for the funding of those services if the same casemix and volume were commissioned.

We intend to develop our approach and expand our evidence base on patient impacts and welcome feedback on how we can improve our future impact assessments. This is a challenging task and may take some time, as more work is required to develop a robust approach.

We also propose to look at the timing of impacts, recognising that benefits may take longer to materialise, and may be more difficult to quantify, than costs. As outlined in the level of detail steps under section 3.2, we intend to monetise costs and benefits or provide an indication of their likely scale wherever possible. In most cases this will mean the financial impact on providers and commissioners. Where we can monetise costs or benefits that occur in the future, we will apply a discount rate to convert them to a present value.[15]

We also intend to consider the extent to which policy proposals are consistent with our broader objectives and responsibilities, and our legal duties, including in relation to integrated care.[16] We will consider the impact of policies in the 2015/16 national tariff on the ability of providers and commissioners to deliver integrated care, where appropriate. Government guidelines suggest a number of specific tests that should be applied when conducting impact assessments.[17] We consider the most relevant of those tests to be related to competition, equality, rural areas and small firms. So in addition to any other tests we consider relevant we intend to assess the impact of our policies on:

[14] For example the data published by CQC as part of its Hospital Intelligent Monitoring programme.
[15] We will follow guidance in HM Treasury's 'Green Book'.
[16] The 2012 Act, section 62(4) and (5) – Monitor must exercise its functions with a view to enabling the integration of healthcare services, and the integration of healthcare services with other health-related services or social care.
[17] BIS (undated), Specific Impact Tests.

- **Competition:** what is the impact of the policy on procurement, choice and competition operating in the best interests of patients?
- **Rural areas:** does the policy have a disproportionate impact on providers, commissioners or patients in a rural area?
- **Small providers**: does the policy have a disproportionate impact on small providers, specialists, independents or charities?
- **Equality:** see the section below.

3.4 Analysis of equality impacts

Assessing the impact on equality of our policy proposals is an important part of complying with our public sector equality duty under section 149 of the Equality Act 2010. We propose to include an assessment of impacts on equality, including those regarding parity of esteem between mental and physical health, as part of our general impact assessment. This should build on the previous equality impact assessments and analysis carried out for previous tariffs.

To help us carry out that assessment and understand the impact of the policies, we will be using the wider engagement and consultation process for the 2015/16 national tariff. This will be an opportunity to ask stakeholders, including those representing individuals with protected characteristics under the Equality Act who may be affected by the proposals, about the potential positive or negative impacts of the proposals, and invite them to submit further evidence in relation to equality issues affecting pricing.

Annex A: Overview of modelling approach to assess impacts

This annex describes the main model we plan to use for the quantitative impact assessment of currencies, national prices and rules for local price-setting in the 2015/16 national tariff. It also describes how we intend to consider the impact of specific price or currency changes on providers, commissioners and patients. Finally, it sets out the metrics we plan to use to assess the impact of the 2015/16 national tariff on the finances of providers and commissioners.

We plan to use a quantitative model to assess incremental impacts by comparing outputs under different policy proposals. For example, we will compare forecast financial metrics using proposed currencies and national prices to forecast financial metrics assuming a rollover of the current (2014/15) national tariff. The output from this approach will illustrate the financial incentives faced by providers and commissioners, but will not attempt to predict any behavioural responses to these incentives. The model allows for a range of sensitivities to be calculated to assess likely impacts for a particular policy proposal, under different projections for provider efficiency and other key variables.

We will use the outputs from the model alongside our broader qualitative analysis, including our assessment of changes in incentives, to assess impacts on patients.

A.1 Structure

We will use a model that operates in three steps:

1. We first project the financial position of commissioners and providers in 2015/16, starting from the most recent audited accounts. This creates the baseline. To do this we need to make assumptions about how the rules on local price-setting (including any proposed changes) are applied by commissioners and providers,[18] and about how costs and revenues change over time. For the purposes of our modelling, we assume that all providers and commissioners use national prices subject to any applicable national variations where applicable, and that they will apply the efficiency and cost uplift factors to all local prices.

2. We then estimate payments from CCGs and NHS England local area teams (who are responsible for commissioning specialised services) to providers using proposed currencies and prices for 2015/16. This forms our policy scenario. The policy scenario will be compared to the baseline from Step 1.

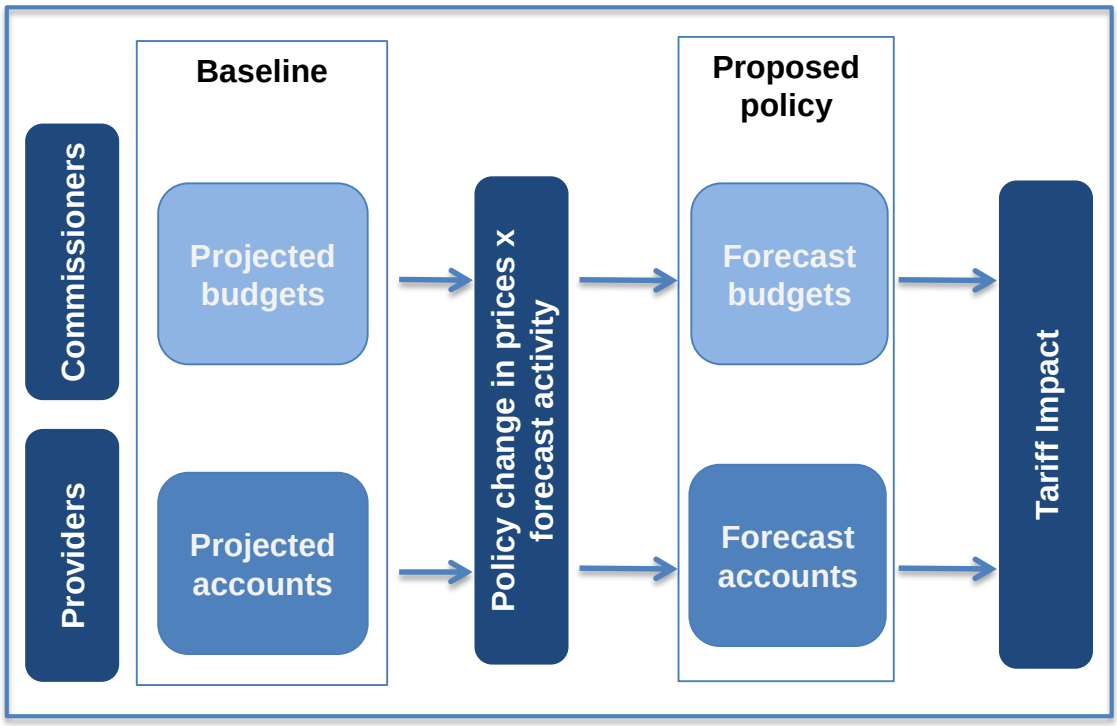
3. The baseline, generated in Step 1, is then updated to include the payments calculated in Step 2. The difference between these forecasts of providers' and

[18] Local payment arrangements must be agreed in accordance with the rules set out in Section 7 of the '2014/15 National Tariff Payment System'.

commissioners' financial position in 2015/16 reflects the impact of changes to the national tariff. As well as new prices, the policy scenario can include other changes that affect national prices, such as different levels for the efficiency factor.

Figure 3 illustrates this approach.

Figure 3: The quantitative modelling approach to assess impacts



A.2 Financial metrics

We are planning to use changes in financial metrics as one way of quantifying the impacts of our proposals. We are considering a range of metrics to measure impacts on commissioners, providers and users of particular types of services.

For commissioners, we propose to assess financial impacts by using a single metric of the change in overall surplus or deficit of a commissioner, for a given level of activity (ie before taking into account the response of the commissioner to the policy proposals). We may look at how far a commissioner's allocation is from what the weighted capitation formula determines they need as one factor to help interpret the results of this metric.[19]

For providers, Monitor already has an established set of metrics (used to assess the financial risk faced by NHS foundation trusts).[20] We plan to apply these metrics to both foundation trusts and NHS trusts. We currently do not have adequate data to

[19] J.Wood & S.Health (January 2014), 'Clinical commissioning group (CCG) funding'.
[20] Monitor (August 2013), 'Risk assessment framework'.

carry out quantitative impact assessments for independent providers, but we are working to develop this capability and welcome thoughts on how we can assess the impacts on independent providers more effectively in future.

For users of particular types of services, we will use a metric to assess the total change in revenue paid for services with national prices for a particular clinical specialty (as defined by chapters of HRGs, such as vascular system or sub-chapters, such as radiotherapy), assuming the volume and mix of services commissioned remain the same.

The following list summarises the key financial metrics we plan to include in our impact assessments for 2015/16:

- commissioner surplus/deficit
- provider net surplus/deficit before public capital dividends
- provider capital service capacity
- provider liquidity days
- changes in chapter or sub-chapter revenue

To calculate these metrics we need to know, in addition to national prices and national variations, providers' costs (including assumptions about their level of investment and whether they pay off debts) and commissioners' budgets. For providers, we will start with the latest available financial position and project it forward based on a range of assumptions. For commissioners, we will use the budgets for 2015/16, which have already been agreed and published.[21]

In relation to the impact of the Better Care Fund (BCF) on providers and commissioners, local authority/CCG partners are yet to publish their plans for their BCF allocation. Therefore, we currently intend to do our modelling based on commissioners' budgets gross of any adjustment for the BCF.

[21] NHS England (December 2013), 'Total CCG Programme Budget Allocations 2014/15 & 2015/16'.

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