Appendices to the 2014/15 *National Tariff: an Engagement Document*

Appendix A - Preliminary Impact Assessment

Contents

A1 Introduction

In line with the statutory requirements, as set out below, we are conducting a preliminary Impact Assessment (IA) for the proposals set out in the *National Tariff 2014/15: An Engagement Document* (the 'Engagement Document') of which this IA is an appendix. It will also form the basis for the IA we will conduct and publish in autumn with the statutory consultation notice on the proposed 2014/15 (National Tariff Document) NTD. We will consult on the published IA alongside the proposed tariff.

In addition to meeting Monitor's statutory requirements, undertaking IAs also helps to assess, improve and refine pricing policy; ultimately supporting Monitor's main duty to protect and promote the interests of people who use health care services. The IA will be particularly useful given the number of tariffs and stakeholders and the overall complexity of the health care system.

The remainder of this Appendix is set out as follows:

Section A.2: sets out our approach to the IA conducted so far and the proposed approach for the on-going IA work to be undertaken leading up to publication of the statutory consultation notice in the autumn.

Section A.3: sets out the objectives guiding the methodology for setting tariffs in the future 2014/15 NTD. It highlights the impacts assessed so far and those to be assessed and published along with the statutory consultation notice in the autumn.

Section A.4: describes the framework we have used to assess impacts of the proposed tariff changes and sets out our initial assessment of the proportionality of impacts on the stakeholder groups we have defined. It also sets out our proposals for specific impact tests we believe we should undertake.

Section A.5: describes the preliminary assessment of impacts from proposed cost uplift and efficiency adjustments and sets out further detailed IA work we intend to conduct and publish with the statutory consultation notice in the autumn.

Section A.6: describes our approach to and outputs of the preliminary assessment of impacts from specific HRG design and tariff changes. It sets out further IA work we intend to conduct and publish in the autumn.

Section A.7: sets out a qualitative assessment of impacts resulting from Local Modifications, Variations and Rules and Enforcement. It describes how we intend to develop this work for publication in the autumn.

A1.1 Context

The Health and Social Care Act 2012 (the "Act") gives Monitor and NHS England responsibility for designing and implementing the reimbursement framework for NHS-funded health care services. The prices and reimbursement rules will be published in the National Tariff Document (NTD).

Monitor has a legal obligation to undertake Impact Assessments (IAs) for decisions that are likely to have significant impacts on patients, NHS providers or the general public or which involve a major change in the

activities Monitor undertakes or in the standard conditions of licences issued by Monitor. In particular, our statutory duty to undertake IAs extends to all policy proposals which are likely to meet at least one of the following criteria (section 69 of the Act):

1. have significant impact on persons who provide health care services for the purposes of the NHS;

2. have a significant impact on people who use health care services provided for the purposes of the NHS;

3. have a significant impact on the general public in England (or in a particular part of England);

4. involve a major change in the activities Monitor carries on; or

5. involve a major change in the standard conditions of licences.

The future 2014/15 NTD is likely to meet the first two criteria as well as the fourth, and the significance of the potential impacts will need to be considered as part of the IA.

Impact assessments are not a new concept for the tariff. The Department of Health (DH) was responsible for setting prices for NHS-funded care up to and including 2013/14, and their process included an impact assessment. When producing their tariffs, DH undertook a "sense check" and "road test" with specific providers and the NHS respectively. The sense check involved sharing of data on the impact on some individual commissioners and providers and asking for feedback and data.

A1.2 This preliminary Impact Assessment

This Appendix (the 'preliminary IA') provides an initial appraisal of the impacts of our proposed changes to tariffs, whilst setting out the proposed approach to be undertaken for the IA accompanying statutory consultation in the autumn. We regard the Engagement Document as an opportunity to engage with health care stakeholders ahead of our statutory duty to consult later in the year. This is in line with good regulatory practice.

Preliminary (or partial) IAs form part of regulatory best practice as they are a mechanism which require regulators to consider the outcomes of their regulatory actions and policy decisions and in so doing, help to shape these actions and decisions. As such, we believe this preliminary IA is sufficient and appropriate for publication along with the Engagement Document. We will produce a fuller IA to accompany the statutory consultation in the autumn.

In the autumn IA we intend to conduct more in-depth analysis and in sections 5, 6 and 7 of this document, we set out some of the Impact Assessment that we intend to conduct.

The Engagement Document sets out our current proposed approach to the 2014/15 national tariff. In particular it contains proposals to amend the 2013/14 national tariff through:

- cost uplift and efficiency adjustments to 2013/14 prices. These comprise uplifts for inflation, changes in Clinical Negligence Scheme for Trusts (CNST) costs, revenue cost consequences of capital (i.e. depreciation and PFI payments), and any additional costs as a result of service-wide requirements (referred to as "service development"). In addition we propose to adjust 2014/15 prices to reflect expected provider efficiency gains;

- specific changes include the addition of new Health care Resource Groups (HRGs) and one-off changes to a limited number of HRGs; and

- the introduction of Local Modifications rules and some changes to existing variations and rules. The Engagement Document also briefly sets out the approach to the enforcement of the national tariff.

This proposed approach to the 2014/15 tariff emphasises stability in the sector, and is based on our core objective of protecting and promoting the interests of patients. Our approach should support both short-term and long-term needs of patients and make sure that prices reflect efficient costs (including our expectations for provider efficiency gains).

We have looked at the impacts across three core impact areas: quality, affordability and financial viability. We look separately at commissioners, providers and patients (where the impacts will be indirect as patients will neither pay nor receive prices). We are concerned to establish the impact on patients, especially on outcomes and quality and would appreciate any further data to help us assess this.

In this preliminary IA, we have not been able to consider all proposed specific and cost uplift and efficiency changes for the 2014/15 NTD, given the unavailability of information to support the estimation of these changes. For example, estimates for the quantitative value of inflation, CNST, consequences of capital and service enhancement adjustments were unavailable. In the work we undertake for the autumn IA, we will use the latest publicly available data.

Our assessment of the other specific HRG and tariff changes that we propose indicates that these would be expected to have only a modest additional impact on provider tariff income. For the majority of providers the impact of these changes is likely to be close to zero, with variations identified between -0.1% and +0.9%.

Q10. We will conduct an impact assessment of the new national tariffs each year. In this we are seeking to identify, describe, and quantify the impacts or consequences of the changes in tariffs on the main stakeholder groups, namely: commissioners, providers and ultimately, patients. In so far as possible, we will conduct our assessment using evidence provided by stakeholders. Where we do not have evidence or the evidence is incomplete or of questionable quality, we shall conduct qualitative (descriptive) assessment of impacts.

To what extent do you agree with our proposed approach to Impact Assessment?

A2 Impact Assessment approach

The purpose of this IA is to identify and analyse the likely impacts of our proposed tariff. This will help us to make sure that the tariff meets our policy objectives and is consistent with our duties under the Act.

This section sets out our approach to IA for pricing at a high level. We have developed our approach by referring to guidance (e.g. the IA Toolkit from HM Government and the Treasury Green Book) and IA precedent (e.g. for regulated pricing regimes in other sectors). We have applied these to the special circumstances of the NHS. In this Appendix, we focus on the impacts of the proposed method for determining prices set out in section 3 of the Engagement Document.

A2.1 Drawing on Impact Assessment guidance

The Act requires that Monitor and NHS England should have 'regard to such general guidance on carrying out Impact Assessments as it considers appropriate'. As such, we have considered relevant guidance in determining the appropriate methodology. There is significant guidance on and experience of conducting IAs across government and regulators.

The approach we followed for the preliminary IA and our proposed approach for the autumn IA draws on general guidance and best practice including:

- The IA toolkit (HM Government 2011);
- The Green Book (HM Treasury 2003 and 2011);
- Department of Business Innovation and Skills (BIS) specific impact tests; and
- Completing competition assessments in Impact Assessments, Office of Fair Trading (2007).

Impact Assessment guidance

The Treasury Green Book is one starting point for developing the framework. The Green Book provides best practice IA guidelines for efficient policy development and resource allocation across government and a consistent appraisal process.

The Green Book outlines the overall method and structure which should be followed for robust ex ante policy assessment.

Consistent with the Green Book guidance, we have:

- followed the broad stages established in the Green Book, such as setting out the key objectives for the 2014/15 NTD;
- identified the main parties and stakeholders affected by the tariff changes;

- specified the options clearly, including a core counterfactual option; and
- undertaken a quantitative and qualitative assessment of the costs and benefits where feasible.

Health care and pricing Impact Assessment precedence

We have built on and developed the approach for IA used by the DH Payment by Results (PbR) team. To inform our methodology, in addition to being guided by the Green Book, we have also considered other IA examples in health care and other sectors.

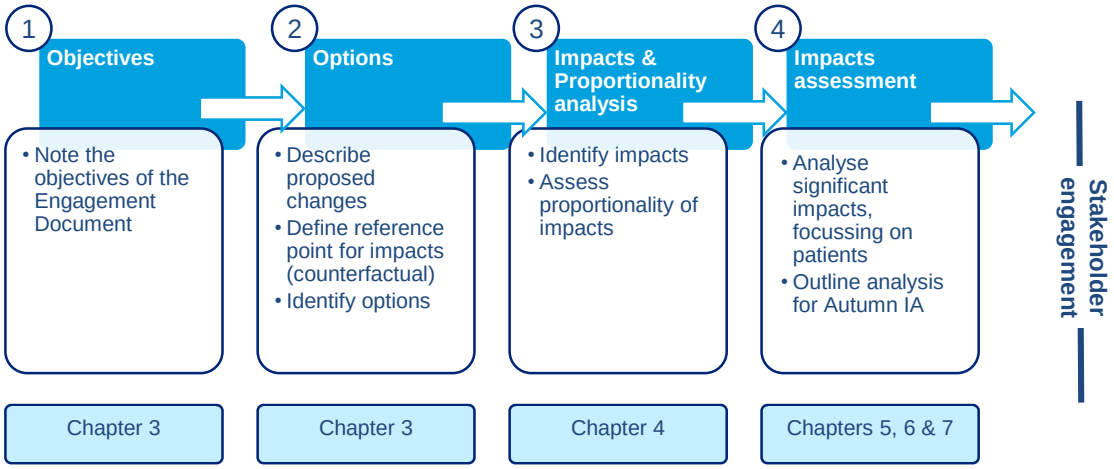
Several of these IAs follow the overall stages established in the overarching guidance, supporting the adoption of these broad stages within this and the autumn IA. However, consideration of IA application in other sectors only provides limited insight relevant to developing the NTD owing to two factors:

1. **The number of services that we set a price for:** There are over 2,500 prices in the tariff. Typically regulatory price controls involve a handful of services at most.
2. **The relationship between price and patients:** In other regulated sectors, typically, consumers pay directly for the regulated services they receive. In these sectors, the analysis focuses on considering consumer welfare through changes in the observed prices. As patients pay for NHS-funded health care services indirectly through taxes and not at the point of use, precedent from other regulated sectors on the methodology to consider consumer welfare changes is less relevant. We have therefore tailored our IA appropriately to the needs of health care and to the tariff.

A2.2 Preliminary Impact Assessment

Our proposed approach for the preliminary IA considers relevant guidance and regulatory precedent, applied to the needs of health care. This incorporates four stages, as summarised in Figure 1. The stages are described in greater detail through the next few sections.

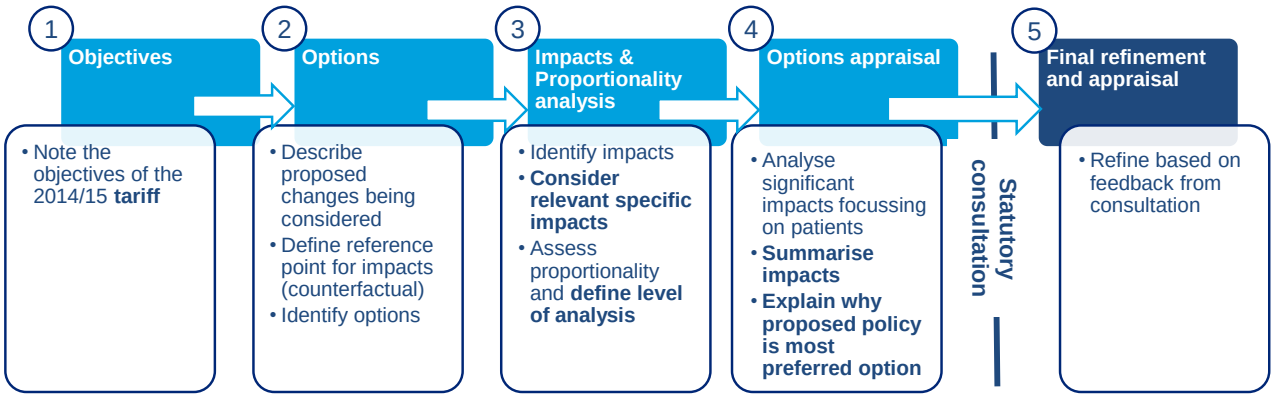
Figure 1: Stages to be conducted for preliminary IA



A2.3 Proposed approach for autumn Impact Assessment

Our approach envisaged for the autumn IA is broadly consistent with that undertaken for the preliminary IA but with more analysis as the prices become more developed. We will publish the full IA for consultation, alongside the statutory tariff consultation notice in the autumn. The full IA will include an explanation of how the discharge of our general duties under sections 62 and 66 of the Act are secured by implementation of the proposed national tariff. The general duties we have identified as most relevant to the tariff proposals are set out in Section 2 of the Engagement Document. The proposed approach is summarised in Figure 2.

Figure 2: Proposed stages for autumn IA



A3 Objectives and options

We noted in the previous section that this IA should help us to make sure that our proposed tariff will meet our policy objectives. This means that we need to be clear about our objectives, and about how we will capture the impacts of our proposed tariff (which are not always obvious).

This section:

- summarises, for the purposes of IA, our objectives in setting the tariff[1];
- identifies the changes that we propose to look at as part of our IA for the 2014/15 tariff; and
- describes how we will define the impacts of these changes.

A3.1 The overarching objectives of the NTD

Our key objective for the tariff is to meet our primary duty[2] to protect and promote the interests of patients, by promoting the provision of services which is economic, efficient and effective, and which maintains or improves the quality of services. This is the most important reference point for the purpose of this IA.

The 2014/15 tariff is the first that Monitor will set in partnership with NHS England. We propose to set a tariff in 2014/15 that places considerable weight on stability in comparison to the 2013/14 tariff. Our overall approach to the 2014/15 tariff has been influenced by two concerns. First, the NHS is going through extensive change already in this year of transition. Therefore to provide additional certainty for the sector, our overall approach to the tariff for 2014/15 is to keep relative prices broadly stable and to seek to publish prices earlier in the year. Second, the new legislation both transfers responsibility for the tariff to new bodies and sets out in some detail a new process for price setting, which requires discussion to be undertaken earlier in the year. These changes create operational risks in this transition year which we have sought to manage by limiting the number of detailed changes.

The proposed methodology is based on the 2013/14 prices being uplifted to reflect the general cost pressures on the NHS as a whole, and adjusted for our expectations for provider efficiency improvements. As discussed in the Section 3.1.1 of the Engagement Document, this approach should help to:

1. encourage the better serving of patient needs in both the short-term and long-term; and

[1] Please see Section 3 of the Engagement Document for a full outline of our pricing methodology, including our principles and objectives.

[2] See section 62(1) of the Act.

2. reflect efficient costs, so that the tariff sends clear signals and incentives to providers (about our expectations for efficiency gains) and commissioners (about the resource costs of health care services).

A3.2 Summary of proposed changes

When calculating prices for 2014/15, our approach is to use the corresponding 2013/14 prices as the base, whilst adjusting for general cost pressures on the NHS as a whole and expectations for improved efficiency on the part of the providers. Some minor changes are also being made with respect to HRG design and tariffs. Sections 4, 5 and 6 of the Engagement Document also include changes that have been proposed with regard to new rules and regulations encompassing Local Modifications, variations and rules and enforcement.

In discussing these changes through the remainder of the document, we have used the following convention:

1. **Cost uplift and efficiency changes.** Changes applied at a national level, to adjust prices so as to reflect cost pressures and expected productivity gains for an average provider.

2. **Specific changes to HRG design and tariffs.** Specific HRG design changes and the introduction of a small number of new tariffs and their associated prices.

3. **Local Modifications; variations and rules and; enforcement**. The introduction of new ways of agreeing variations deviating from national prices.

Cost uplift and efficiency adjustments

Section 3 of the Engagement Document proposes a range of 3% to 4.5% for the efficiency adjustment[3]. With regard to the cost uplift and efficiency adjustments, the inflationary uplifts we will apply for the autumn IA are yet to be confirmed and we have therefore not considered them in this IA. Further, given the unavailability of CNST adjustments, depreciation and PFI costs and service enhancement costs for June, the cost uplift and efficiency level impacts we have evaluated in this preliminary IA have more simplified impacts on commissioners and providers than will be the case in the autumn IA.

With regard to the Specific HRG and tariff adjustments, we have conducted a quantitative analysis where new prices and data were available. Where these were not available, we plan to include further quantitative analysis in the autumn IA.

[3] We note that, whilst we have set out a range for the suggested efficiency adjustment, the final adjustment selected may fall outside of this range.

Regarding other adjustments, we have conducted an initial qualitative assessment of Local Modifications and of enforcement. We will be developing this assessment between now and the autumn. Likewise for variations and rules, we will conduct further IA work on these and include the results in the autumn IA.

Specific HRG and tariff changes assessed in this preliminary Impact Assessment

Specific adjustments assessed so far include a limited number of proposed price changes which will impact only a subset of services[4] and/or providers and commissioners encompassing:

- HRGs design changes (new tariffs for 2014/15):
    - laparoscopic/open kidney and ureter procedures;
- tariff changes to correct an oversight in the 2013/14 tariff:
    - major IR hepatobiliary procedures RC31Z;
- HRG logic changes to correct pricing issues:
    - spinal surgery HC02/HR02; and
    - electroencephalograph telemetry AA34C/AA34D.
- Design changes for 2014/15 (no tariff change):
    - physical abuse / trauma;
    - stapled transanal rectal resection for obstructed defecation syndrome; and
    - fractional flow reserve.

The following specific adjustments are not included in the analysis. We provide reasons for omission and, so far as possible, our initial estimated scale of impact at a national level:

- Design changes for 2014/15 (no tariff change)
    - Intravenous induction of labour

      Activity affected by this change is extremely low. In addition, maternity services (which are covered by the pathway tariff) have been excluded from the analysis due to absence of a full-year, national activity dataset.
    - Dialysis for acute kidney injury

[4] See section 3 of the Engagement Document for more details.

Services remain outside the scope of the national tariff i.e. do not have mandatory prices.

- Remapping of OPCS codes from extended categories

  Implementation of change would lead to activity being grouped to UZ01Z i.e. zero priced. It is assumed that organisations will re-code their activity to remove this issue and so the change will have zero impact.

- Move from local to national tariffs:
  - unbundled diagnostic imaging in outpatients

    Tariffs for diagnostic imaging were unbundled from outpatient attendances in 2013/14. To mitigate the financial risk of an increase in diagnostic activity, a marginal rate of 50% of the national tariff was introduced for the payment of any activity above the trend growth. The marginal rate will be maintained in 2014/15 with the baseline adjusted for the expected growth in 2014/15. The flexibility that existed in 2013/14 for providers and commissioners to share the overall impact will not be available in 2014/15 and the national tariffs should be used. We will assess the impact of this change in the autumn IA if we have sufficient data to analyse although we are not sure that this will be the case.

  - Maternity pathway tariff sharing

    Tariff sharing flexibilities will continue to be available for providers and commissioners to share the impact of the introduction of a maternity pathway tariff in 2013/14. In 2014/15, we propose that this will be the last year that the tariff sharing flexibilities are available and providers and commissioners should ensure they move towards the national prices in 2014/15 in preparation for full implementation in 2015/16. We will assess the impact of this change in the autumn IA if we have sufficient data to analyse.

- New tariffs for 2014/15:
  - Complex therapeutic endoscopy

    New price yet to be determined. It is expected this will be included in the analysis for the autumn IA.

  - Complex bronchoscopy

    New price yet to be determined. It is expected this will be included in the analysis for the autumn IA.

- Best Practice Tariff changes:
  - Paediatric Diabetes

Excluded from analysis due to the absence of full-year, national activity dataset. However, it is known that there are around 23,000 children with diabetes in England. Based on this, the impact of the change is likely to be an increase in provider income of between £5m and £10m.

- PROMS for primary hip and knee replacements

  This will be included in the analysis for the consultation in the autumn.

- major trauma

  The recommendation from the Major Trauma Clinical Reference Group (CRG) is that we should continue to make best practice stretching. In 2014/15 we are proposing to change and add to some of the existing criteria for Level 1 and 2 payments.

Overall, we expect these specific adjustments to impact a very limited number of prices in the NTD.

Introduction of Local Modifications, Variations and Rules and Enforcement

Other changes are not changes to prices but changes to the way that national tariffs can be adjusted for either local conditions (using Local Modifications) or for certain groups or providers (variations and rules) and how we are seeking to use enforcement to ensure that any adjustments away from the national tariff are captured within the new regulatory framework.

In this preliminary IA, we have been unable to assess the impact of all changes, given the lack of data availability supporting the calculation of all the adjustments for the future 2014/15 NTD. Table 1 outlines the adjustments that are considered in this preliminary IA and those which will form part of the autumn IA.

Table 1: Adjustments considered by IA

	Adjustment	June	Autumn
Cost uplift and efficiency	**CNST**	×	✓
	Efficiency	✓[5]	✓
	Inflation		
	i. Pay settlements	×	×
	ii. Pay drift	×	✓
	iii. Drugs	×	×
	iv. Non pay, non drugs	×	✓
	Depreciation & PFI payments	×	✓
	Service enhancements	×	✓
Specific HRG and tariff	**HRG design and pricing changes**	✓	✓
Other	**Local modifications**	✓	✓
	Variations and rules	×[6]	✓
	Enforcement	✓	✓

A3.3 Options considered in the preliminary Impact Assessment

Section A3.2 described the changes that we propose to consider for the 2014/15 tariff, but for an IA we need to define how we will capture[7] the *impact* of these changes. This means that we need a different scenario to compare our proposals against – a 'counterfactual scenario'. This counterfactual should be a plausible alternative to our tariff proposals.

In this preliminary IA, we have used the prices and currencies in the 2013/14 tariff, without any uplifts or adjustments, as the counterfactual. This counterfactual is a plausible alternative tariff for meeting our objectives in 2014/15, particularly that of stability. It is also consistent with the Green Book which recommends that the current policy in place – in this case, the prices in the 2013/14 tariff - should be considered as a counterfactual.

[5] Using scenario analysis.

[6] Specialist top ups (a local variation) are assessed as part of the June IA within the specific changes relating to new HRGs and HRG changes.

[7] Ideally, we would be able to quantify impacts. This is not always possible, but there are sometimes other ways to identify and analyse impacts, even if they cannot be measured precisely.

For the purposes of defining our counterfactual scenario for this IA, we have not made any assumptions about changes to provider costs or demand for services.

DQ16. Do you agree with the choice of the 2013/14 national tariff as an alternative option to test the impacts of the changes proposed for the 2014/15 NTD? If you disagree, please indicate which other options we could consider the impacts against.

A4 Impacts and proportionality analysis

This section sets out the impacts that we propose to include in the IA for the 2014/15 tariff. These proposed impacts are guided by the key concepts for this IA that were set out in the previous section: our objectives, the changes arising from the 2014/15 tariff that we propose to look at, and the way that we will capture the impacts of those changes.

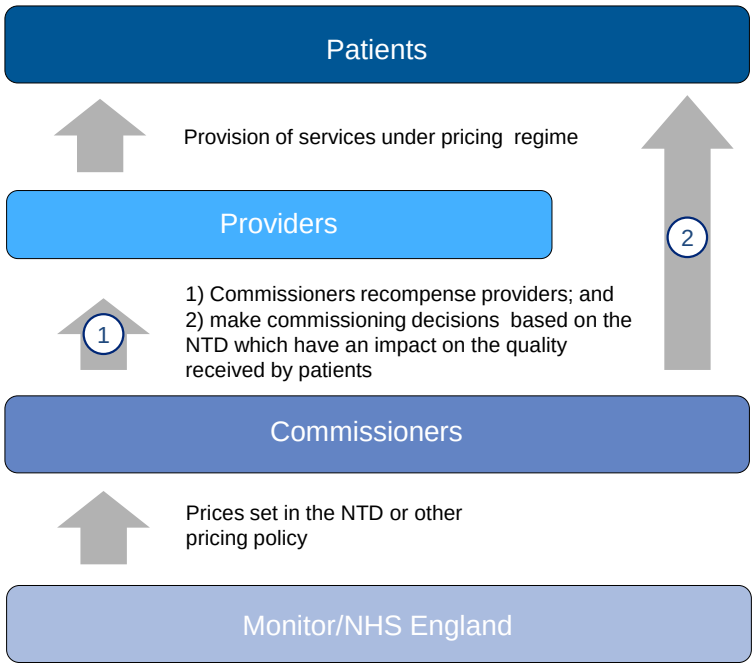
We do not propose to analyse all of these impacts to the same extent. Instead, our analysis will be proportionate to the likely magnitude of the impacts (on patients, in particular) and the likely strength of evidence that will be available to us for the 2014/15 tariff. This section includes a 'proportionality assessment' for our proposed impacts, to indicate the likely extent of our analysis for the autumn consultation.

This section also sets out specific impact tests outlined by the Better Regulation Executive of the Department for Business, Innovation and Skills (BIS).

A4.1 Relevant stakeholders

Pricing changes for NHS-funded services could have impacts on commissioners, providers and patients. The transmission of impacts across these stakeholder groups is summarised in Figure 3.

Figure 3: Summary transmission mechanism



Commissioners pay for services, and will be primarily interested in maximising value for patients within the constraint of their budgets. Providers receive payments from commissioners (for tariff services), and must

make sure that they recover their costs. Providers will make choices with regard to service delivery and service offerings in response to the payments they receive and commissioning decisions, which will have indirect impacts on patients. However, this transmission mechanism could become more complex due to the following factors:

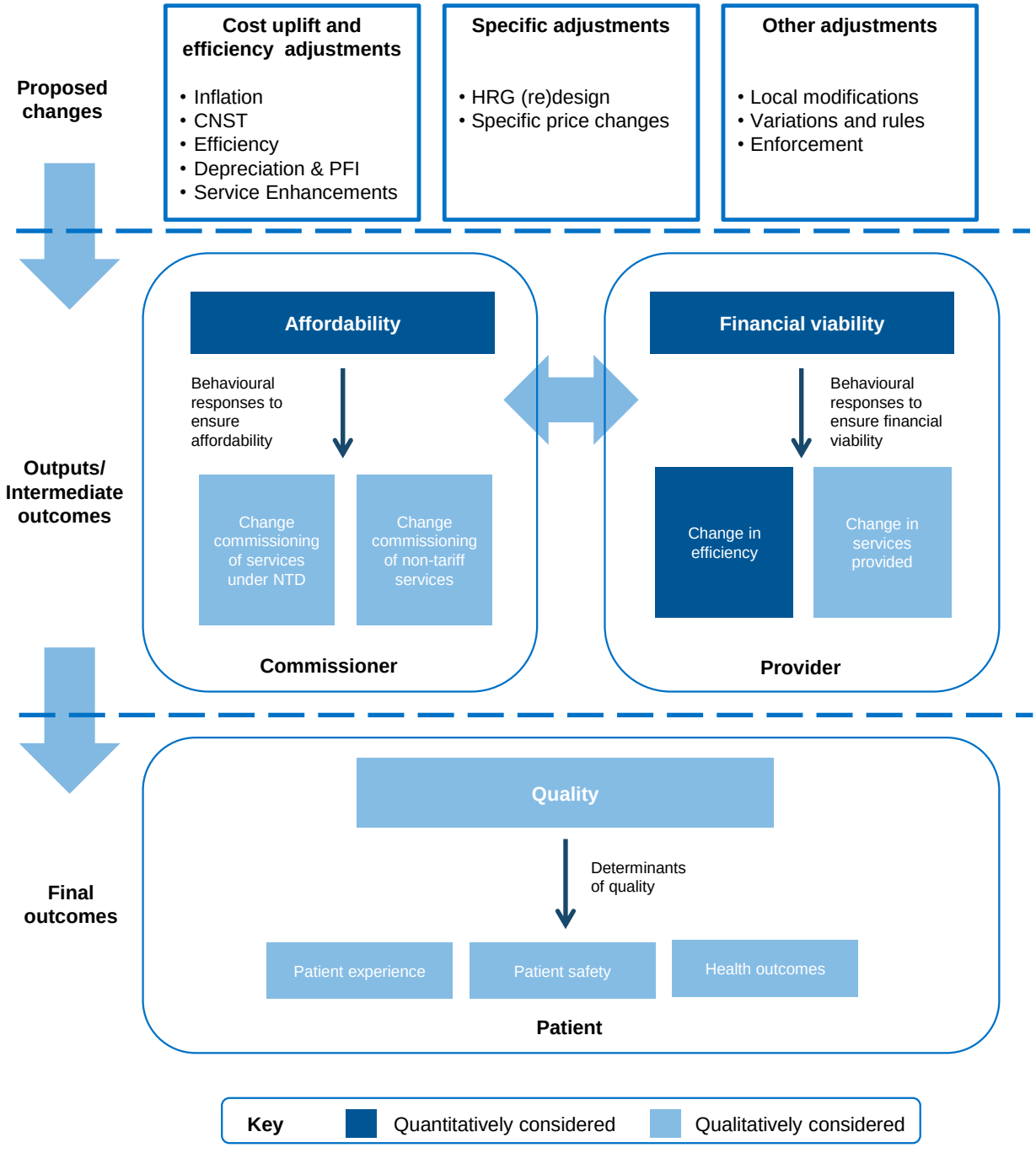
- as prices change commissioners may change their commissioning behaviour for tariff or non-tariff services;
- providers could enter or exit markets for particular services, or be forced to change their method of service delivery (which might involve risks to quality of service); and
- patient demand may change over time (due to demographics for example), influencing the impact of pricing.

A4.2 Overarching impacts

For all changes we are proposing for the 2014/15 NTD, we have identified a number of potential impacts, as shown in Figure 4 below. We have categorised these impacts into three broad areas:

1. **Quality of service for patients.** Service quality, as measured through patient experience, patient safety and health outcomes, could be impacted from changes in the delivery of health care services from the pricing incentives impacting commissioning and provider behaviour.
2. **Affordability for commissioners.** The NTD prices may impact the overall affordability for commissioners, given the national budgetary allocations. If a significant change is expected to affordability, there may be changes in commissioning behaviour, particularly given CCGs have a statutory duty to ensure that their purchasing decisions achieve budgetary balance.
3. **Financial viability for providers.** Tariff changes could impact providers' financial viability and their ability to continue delivering high quality services, or continuing to provide services at all. If price changes significantly impact viability, providers may respond by agreeing a local modification, ceasing provision of some non-mandated services or making efficiency enhancements.

Figure 4: Flow of impacts



A4.3 Proportionality of impacts

To determine the level of analysis to be conducted for each impact, we have made a high level proportionality assessment. This assessment considers:

- the potential scale of the impacts on the relevant stakeholder group; and
- the strength of the evidence available.

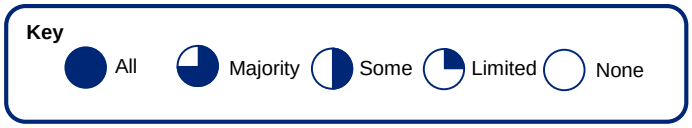
Following this assessment, a level is assigned to each impact, describing the detail the preliminary IA should seek to achieve in evaluating the impact. If the potential scale of impacts is likely to be low or not material, or if available data is not sufficient to conduct a robust quantitative analysis, the impacts should be identified or described. If impacts are likely to be material, best practice recommends quantification where feasible. As such, the four levels of analysis proposed are:

- **Identify:** impacts are identified.
- **Describe:** a qualitative description and appraisal of the impacts drawing on some relevant literature or evidence where available.
- **Partially quantify:** a limited quantification of impacts using available information.
- **Quantify:** more detailed quantification is conducted, possibly involving forecasting and behavioural changes.

A summary of the results of this proportionality assessment is provided in Table 2.

Table 2: Proportionality assessment for the cost uplift and efficiency level adjustments

Key impacts	Stakeholder group	Potential Scale	Data availability	Level of impact analysis
Quality	Patients			Identify
Affordability	Commissioners			Partially quantify
Financial viability	Providers			Partially quantify



Based on only a limited set of cost uplift and efficiency adjustments being available for the preliminary IA, the scale of the impacts appears to be small at this stage. However, these impacts are likely to be more significant for some providers dependent on the extent to which they make efficiency improvements compared to the efficiency factor we use to determine the prices that will feature in the 2014/15 NTD. Commissioners are likely to find that affordability improves. This is particularly driven by the inflation and efficiency impacts being service independent, therefore applying equally across all HRGs. At this stage it is unclear how significant these impacts will be as we do not have the necessary data to conduct a full Impact Assessment at the time of writing. The scale of these impacts should be clearer in the autumn IA. The impacts on commissioners and providers are identified in this assessment to be greater than patient impacts. This is due to pricing changes impacting commissioners and providers more directly.

Data availability for Impact Assessment was limited at the time of writing in a number of regards, including:

- HES information covering activity for the full financial year 2012/13 had not been published;
- financial information on providers from Financial Information Management Systems (FIMS) for 2012/13 was not yet available; and
- budgetary allocations to CCGs for 2014/15 had not been published.

As for cost uplift and efficiency level adjustments, we have also conducted a proportionality assessment for the specific HRG and tariff changes.

Table 3: Proportionality assessment for specific HRG and tariff adjustments

Key impacts	Stakeholder group	Potential Scale	Data availability	Level of impact analysis
Quality	Patients			Identify
Affordability	Commissioners			Partially quantify
Financial viability	Providers			Partially quantify

Based on the specific adjustments being made and for which we have data to allow meaningful analysis for the preliminary IA, the scale of the impacts is very small at an aggregate level. With more data expected after this preliminary IA, we expect to be able to quantify further these impacts in the autumn IA. We believe the impacts on commissioners and providers identified in this assessment are potentially greater than patient impacts which are indirect resulting from changes to providers' and commissioners' finances.

DQ17 Do you agree with the overall cost uplift and efficiency and specific impact areas identified (affordability, financial viability and quality)? Please identify any other impact areas we should consider.

A4.4 Other specific impact tests

The Better Regulation Executive of BIS recommends that consideration be given to a range of impact areas 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.'* [8] The guidelines list ten specific tests, covering a broad range of economic, social, environmental and sustainability impacts.

In order to help support a robust IA, we considered each of the impact areas. However, it is to be noted that the relevance and proportionality of each of the specific impacts is dependent on the policy change being proposed and the options being considered.

Table 4 below, lists the specific impact tests, and assesses their potential relevance to the autumn IA. In this preliminary IA we only consider the specific impacts in so far as they cross over with the impacts established in Section A4.2.

We have classified specific impact tests as *de minimis,* under the following two conditions:

1. there is no clear direct or indirect link between the impact area and pricing of health care services; and

2. 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.

In all other cases, we have classified impacts as being of high or medium relevance.

[8] http://webarchive.nationalarchives.gov.uk/+/http://www.bis.gov.uk/policies/better-regulation/policy/scrutinising-new-regulations/preparing-impact-assessments/specific-impact-tests

Table 4: Specific impacts and their relevance

Specific test	Proposed autumn IA scoping of test	Summary notes
Competition	Medium	• Secondary effects following viability and affordability impacts • Relates further to patient choice considerations
Health	High	• Will be considered through the quality impact area
Rural proofing	Medium	• Secondary effects following viability and affordability impacts
Small firms	Medium	
Equalities	De minimis	• Impacts unlikely to be significant and specific discussion not required
Sustainable development		
Wider environment		
Greenhouse emissions		
Human Rights		
Justice		

A detailed description of the proposed scoping of the impact tests, subject to data and information limitations, is discussed below. We will be holding a series of workshops with commissioners and providers in the lead up to the autumn and we intend to gather empirical evidence during these workshops on these areas of potential impact from the stakeholder groups.

Competition

According to the OFT guidelines[9], IAs should include a competition assessment for policies which directly or indirectly limit the number or range of providers, or, restrict the ability or incentive of suppliers to compete. Tariff changes could lead to impacts on competition such as variations to market entry and exit conditions or incentives to consolidated service provision across providers.

The autumn IA will qualitatively consider at a high level any second order impacts on the provider landscape from changes in viability or affordability.

[9] Completing competition assessments in Impact Assessments: Guideline for policy makers, Office of Fair Trading, 2007

Health

Health IAs (HIAs) are designed to assist those responsible for developing and delivering policy proposals to consider the potential impacts on health outcomes and inequalities. In particular, the HIA ensures that the proposed changes do not have unintended adverse impacts on health outcomes or health inequalities.

The NHS guidance[10] on undertaking HIAs recommends that a preliminary screening of the likely health impacts be conducted, using readily available evidence and review of current evidence in order to determine the level of analysis required. This preliminary IA forms the scoping and screening stages of an HIA.

The ultimate objective of the tariff is to promote the quality of service provision and provider efficiency, so as to enhance patient health outcomes. However, changes to health outcomes will not directly be impacted through the NTD but manifest through changes in commissioning and the efficiency and cost of services provided. These impacts could also be relevant for health inequalities which refer to the 'systematic differences in health status between different socio-economic groups'.[11]

Given the limited changes being considered for this preliminary IA, material impacts on health outcomes and inequalities are not expected. At this stage, we believe the qualitative discussion surrounding patient level impacts on quality is sufficient and appropriate.

For the autumn IA a similar approach is proposed, whereby the health impacts will be analysed through the impacts on quality.

Rural proofing

Rural proofing requires that the policy proposal takes into account the interests of rural people, businesses and communities. Specifically, the policy makers are required to consider whether there are any significant impacts on rural areas and adjust the policy to ensure that the needs of the rural population are addressed fairly. Impacts from changes in financial viability and affordability could be more material in rural settings where the concentration of providers, particularly for acute services, is lower.

For the autumn IA, we intend to analyse the potential impacts on rural people, businesses and communities as part of a distributional analysis around financial viability and affordability, subject to the availability of appropriate Geographic Information System (GIS) data to allow us to do this.

Small firms

The small firms impact test defines firms with less than 20 full time equivalent (FTE) employees as small firms and those with fewer than 50 employees FTE as small businesses. Specifically, the test examines

[10] NHS Health Development Agency (2002), Introducing health impact assessment (HIA): Informing the decision-making process

[11] WHO (2007), Levelling Up: Social inequalities in health concern systematic differences' in health status between different socioeconomic groups.

whether alternative approaches are appropriate for small firms and small businesses can be given a partial exemption from the new rules. Providers of health care services are typically classed as 'small and micro' if they have fewer than 50 FTEs and income from health care services of less than £10m.

Changes in tariff prices and design could impact small firms, particularly given the potential presence of economies of scale in the provision of health care services.[12] As such, the impacts on small firms should be considered in the autumn IA, to the extent that we have sufficient data to do so. We propose that these should be primarily considered as part of a distributional analysis around financial viability and affordability for NHS providers.

Equality

Under the Equality Act 2010, Monitor is required to have due regard for groups with protected characteristics. The Act considers the following characteristics as protected: age, race, pregnancy and maternity, disability, religion or belief, sex, sexual orientation and gender reassignment.

Typically, equality considerations are more relevant to Impact Assessments where particular services are more or less heavily used by particular groups of people. As the majority of the changes for 2014/15 are not service specific, our initial view is that there is unlikely to be any significant impact and that a full equality analysis may be unnecessary. However, we will consider this further as part of developing the Autumn IA and would welcome any views on our proposed approach and any potential impacts.

Human rights and justice

The human rights and justice specific impact tests are both covered by guidelines provided by the Ministry of Justice (MoJ). The human rights test requires the policymaker to state whether the proposal will have human rights implications. Human rights, as defined by the MoJ, are "*rights and freedoms that belong to all individuals regardless of their nationality and citizenship."* However, the guidance also states that this area, if relevant, will be covered under the equalities impact area discussed above. A separate assessment will therefore be redundant.

The Justice Impact Test considers the impact of a proposal on the justice system. This includes impacts on the courts, and tribunals, prisons and probation, the legal aid budget, or the prosecuting bodies and judiciary. As the impacts of the future 2014/15 NTD are unlikely to have direct or indirect effects on the justice system we propose that this test is not considered in the autumn IA.

Greenhouse gas emissions

The Department of Energy and Climate Change (DECC) provides guidelines which apply to any policy change that has net impacts on greenhouse gas emissions over its lifetime. There is no clear linkage between pricing policy and greenhouse gas emissions. We therefore propose that this test is not considered in the autumn IA.

[12] Further, it is noted that small providers also have to comply with national tariffs, defined under Monitor's pricing licence condition 4.

Wider environmental impacts

This test is designed to assess the wider environmental impacts of policy options such as impacts on air quality, water quality and quantity, flood risk, biodiversity, landscape and noise. Based on evaluating the proposals set out in the Engagement Document (and expected to form the basis of the future 2014/15 NTD) against the checklist provided by the Department for Environment, Food and Rural Affairs (DEFRA), no clear linkage can be established between health care service pricing policy. We therefore propose that this test is not considered in the autumn IA.

Sustainable development

The sustainable development impact test is typically conducted to ensure that the proposed policy does not compromise the position of future generations; whilst ensuring that the current generation satisfies its basic needs. As per DEFRA guidance, impact on sustainability encompasses environmental standards, intergenerational impacts and the social aspects of the proposed policy change. However, given that the NTD is revised annually, we propose that this test is not considered in the autumn IA.

DQ 18 Do you agree with our assessment of the relevant specific impact tests for the autumn 2013 Impact Assessment?

If you disagree, please describe what other areas we could consider, how we could assess the impacts and what data we would need.

A5 Impact assessment – impacts of cost uplift and efficiency adjustments

This section provides our preliminary assessment of the potential impacts of the cost uplift and efficiency adjustments to prices in the 2014/15 tariff, as set out in Section 3 of the Engagement Document.

In Section A4.2, we proposed considering impacts aligned to the key stakeholder groups: commissioners, providers and patients. Based on the cost uplift and efficiency adjustments which are available at the time of writing this IA, we have not seen any evidence yet of significant impacts. However, once the efficiency adjustments are applied, we expect the impact on providers to be clearer, and these impacts will depend on their (individual) capacity to deliver efficiency improvements in proportion to our expectations. We expect to include a more thorough analysis of provider impacts in the autumn IA.

At the end of this section, we propose some further analysis to consider these impacts in greater detail in the autumn consultation.

A5.1 Preliminary commissioner level impacts

Under the Act, CCGs have a statutory duty to ensure that that their expenditure does not exceed their allocation from NHS England. As such, CCGs have an incentive to achieve budgetary balance. Given this incentive, if tariff changes negatively impact on affordability CCGs could, for example, look to control more actively their payments for activity over pre-agreed limits with providers.

Based on an initial assessment of proportionality, as discussed in Section A4.3, CCG affordability impacts are partially quantified.

Affordability

We have conducted two tests to consider the potential impact of the available cost uplift and efficiency adjustments to prices for the future 2014/15 NTD.

Firstly, we considered changes in tariff expenditure at a CCG and national level. Based on the available cost uplift and efficiency adjustments, we are engaging on a proposed real reduction in prices of between 3% and 4.5% to be applied across all HRGs. Commissioning spend on services under the NTD could, therefore see an estimated real decrease within the range of 3% and 4.5%, not accounting for CNST, depreciation, PFI or service enhancement adjustments. This analysis however, does not account for potential changes in activity growth, which could abate this improvement to affordability.

Analysis of changes to CCG expenditure in isolation also does not consider how these changes compare to budgetary allocations, to measure the impact on overall affordability. CCG allocations from NHS England for 2014/15 are unpublished at the time of writing. Without prejudging NHS England's allocation decision, a scenario whereby the change in overall allocations for 2014/15 follow the change from 2012/13 to 2013/14 was considered. In 2013/14 the total CCG allocation for the commissioning of services was £63.4 billion

representing a 0.3% real growth rate[13] over the 2012/13 baseline[14]. If the Treasury's estimates for inflationary uplifts are consistent with the uplifts being considered by Monitor, the real percentage change is reflective of the net change observed by the CCGs. Thus if budgetary allocation continued to grow at the same rate, CCGs could see an effective increase in net surplus, in the range of 3.3% to 4.8% when considering services covered by the NTD.[15]

Summary

On the basis of this preliminary impact analysis, CCGs are likely to benefit in real terms, in the form of increased net surplus which could be invested in further health care services. However, we note that any measurement of the impacts before all inflationary uplifts are applied and CNST, depreciation, PFI and service enhancement adjustments are made, will not provide a full account of the actual scale of the impacts. We have outlined analysis proposed for the autumn IA in Section A5.4. and this will need to take account of the further adjustments.

There are also potential benefits to CCGs from the NTD providing clearer pricing signals in the long run. Improved pricing signals could allow commissioners to make more informed commissioning decisions potentially benefiting patients. However, the potential scale of these benefits is difficult to quantify.

A5.2 Preliminary provider level impacts

Tariff changes could have direct impacts on providers' financial position, through changes in provider income. In addition, second order effects could occur as prices create incentives for efficiency improvements or wider service change. Changes in financial position could also lead to changes in market entry or exit conditions or service consolidation, altering the level of competition between providers. We consider these potential impacts through a preliminary analysis of provider financial viability.

Based on the initial proportionality assessment, discussed in Section A4.3, the preliminary Impact Assessment of provider financial viability is partially quantified by considering changes to the providers' financial position.

Financial viability

The impact of the cost uplift and efficiency adjustments on financial viability could be assessed by looking at the overall impact on a number of financial indicators for providers. As a first step, we considered the change in income for providers, holding volumes constant. The cost uplift and efficiency adjustments lead to a downward adjustment of 3% to 4.5% in real terms, across all HRGs. Holding activity levels constant therefore, we expect a corresponding decrease in real income across all providers.

[13] See http://www.england.nhs.uk/2012/12/17/everyonecounts/

[14] The baseline has been defined by NHS England (formerly NHS Commissioning Board). See http://www.england.nhs.uk/wp-content/uploads/2012/12/ccg-allocations-13-141.pdf

[15] It is to be noted that the budgetary allocation to commissioners also incorporates commissioning spend on healthcare services not within the scope of the NTD.

Summary

The preliminary analysis outlined above does not fully capture the impact on the providers' financial viability which also incorporates the cost of providing health care services. The estimated inflation and efficiency adjustment implicitly assumes that, on average, provider costs should decrease in real terms by 3% to 4.5% (dependent on the outcome of our engagement on the efficiency level for 2014/15), due to efficiency and productivity enhancements. For providers meeting this efficiency target, there will theoretically be no net impact on margins from the cost uplift and efficiency adjustments to tariff on their financial position. However, in reality provider efficiencies are not uniform and as such will lead to varying impacts on financial viability. We will assess the impact of these adjustments fully once decisions are made on the efficiency adjustments and cost uplifts. The potential analysis that could be undertaken for the autumn IA is set out in Section A5.4.

Maintaining a broadly stable tariff could support more informed decision making by lowering the inherent risk associated with investments. This could provide stronger incentives for improvements in quality and efficiency, potentially leading to enhanced patient experience and outcomes.

A5.3 Preliminary NTD patient level impacts

Tariff changes are not directly observed by patients. Patient level impacts manifest themselves through provider and commissioner responses to changes in tariff. These potential impacts are discussed below, through a consideration of the impacts on patient quality, encompassing patient outcomes, patient safety and patient experience.

Quality

As discussed in the proportionality analysis in Section A4.3 the impacts on patient choice and quality are not likely to be significant given the changes considered in this preliminary IA. Providers may achieve efficiency gains of between 3% and 4.5%. The inability to meet efficiency targets may lead to a decrease in operating margins and potentially impact quality. However, there is currently very little empirical evidence on the link between prices of health care services and the quality of service provision.[16]

Summary

Patient level impacts through changes in providers' financial viability and commissioner affordability are likely to be limited, given the limited adjustments being considered. However, there could be the opportunity for some improvements in patient outcomes particularly through more informed commissioning, related to clearer pricing signals and to a volume effect brought about by a potential fall in real prices. This would allow commissioners to buy more services for a given budget. We will need to reconsider these potential impacts in light of further adjustments being applied in the autumn IA.

[16] The King's Fund (2012), *Payment by results: How can payment systems help to deliver better care*?

A5.4 Proposed outline for the autumn Impact Assessment of price uplift and efficiency gains

This section describes the analysis we propose for the autumn IA. Our analysis will be refined as we investigate further the data available and get more feedback about our proposals from stakeholders. In conducting further analysis for the autumn, we will use the latest data available.

Overarching principles for autumn Impact Assessment

We propose to conduct the autumn IA adhering to a number of overarching principles:

1. all available adjustments to reach the proposed 2014/15 NTD will be considered where feasible;

2. impacts will be assessed across the three identified main stakeholder groups: patients, commissioners and providers;

3. activity information will be drawn from the most recently available data, within a reasonable timeframe[17];

4. largely the analysis will compare the NTD 2014/15 to a counterfactual of continuing with the prices and currencies established in 2013/14;

5. where possible a single source of information will be used, although in some instances multiple sources may be required; and

6. changes in demand for services based on demographic trends or behavioural responses will not be quantified.

The latter assumption is appropriate for the autumn IA given the current availability of reliable forecasting information and the limited nature of empirical literature assessing pricing related behavioural responses. We may conduct some high level sensitivity and scenario analysis to explore these impacts in more detail.

Commissioner level impacts

The cost uplift and efficiency adjustments to tariff will not be HRG specific (except for CNST changes which relate to groups of HRGs or subchapters) and therefore will not have differential impacts across commissioners based on local health needs. Our analysis of impacts on commissioners will consider tariff expenditure at both an individual and aggregate level and compare expenditure to possible budgetary allocations.

[17] Potential sources of information could include HES or reference cost returns.

Affordability

C1. Change in CCG expenditure. For the autumn, we propose to conduct a CCG level analysis multiplying each of the proposed tariffs by the latest available purchasing information, comparing the expenditure using the 2013/14 tariffs to the NTD 2014/15. Aggregating total expenditure across all CCGs will also provide an overall assessment of national affordability. For the main analysis, we will hold activity constant to understand the pure pricing impacts. We may perform a sensitivity analysis to consider some high level variations to activity.

C2. Potential impact on CCG and national affordability. We could compare changes in CCG expenditure to different scenarios for budgetary allocations to CCGs. This analysis could use the observed 2012/13 to 2013/14 allocation change, as utilised in the above analysis, as an initial scenario to evaluate.

C3. Distribution of impacts across CCGs. We could analyse changes in CCG affordability, across the country to identify those CCGs which experience disproportionate impacts. For CCGs materially impacted, contingent on the data available, we could qualitatively assess the potential impacts on health inequalities. [18]

Provider level impacts

We propose in the first instance to focus on the impact to providers' financial position and viability. Additionally, impacts may vary based on geographical location, size or type of service offering. Based on the final set of adjustments proposed and available data, we could assess distributional impacts across providers by segmenting them into groups according to their size (turnover or FTEs), type (acute or other) and location.

Financial viability

P1. Change in income across providers. We propose to conduct a provider level analysis multiplying each of the proposed tariffs by the latest available provider activity information. Results could be compared using the 2013/14 tariffs and the future 2014/15 NTD to understand the change in provider income. This analysis could be extended to understand some high level variations to activity, where this is expected, using scenario analysis.

P2. Change in net surplus by provider. The analysis of income changes only considers the income effect of the price change. In order to consider a broader measure of changes to financial viability, we could combine cost information to estimate changes in net surplus.[19] We propose to undertake

[18] This is important because allocation decisions to commissioners have been based on local health inequalities. Historically, DH allocation decisions for Primary Care Trusts (PCTs) have been based on a weighted capitation formula which weights the allocation to allow for the extra health needs faced by disadvantaged areas. This is to ensure there is sufficient funding to provide equal access for equal needs in all parts of the country and to reduce avoidable health inequalities.

[19] The precise measure of surplus will be defined around the cost information which is available.

this analysis depending on the availability and quality of provider level data on costs. Where information is unavailable a scenario analysis considering a number of high level provider types could instead be included.

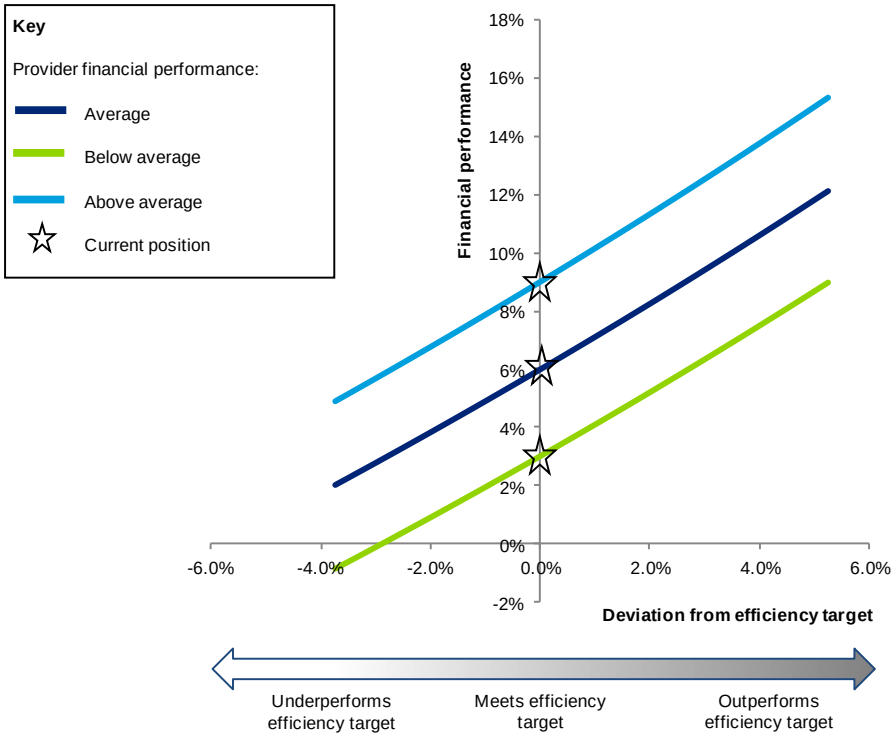
P3. Distributional impacts. Once all adjustments are accounted for, impacts across providers may not be uniform. For instance, materiality of impacts may vary by provider type, size or location. Based on the impacts on financial viability and the nature of data available, we may consider undertaking an analysis of the distributional impacts across providers in the autumn IA. This analysis could consider impacts on financial viability against factors such as geographical location, provider type and provider size.

P4. Scenario analysis. The proposals for price setting for the 2014/15 tariff consider that expected efficiency gains for providers in a range between 3% and 4.5% may be appropriate. However, given the varying actual efficiency levels among providers and different operating margins, there may be differential impacts on financial viability. A reduction in tariff derived income should lead to an overall flat impact on provider margins should the efficiency assumptions be realised by providers.

As an illustrative example, Figure 5 below provides a simplified consideration of how deviation from the efficiency target can impact margins for different provider types. For a provider with an initial operating margin of around 3%, not meeting the target efficiency level by more than 3% will lead to margins turning negative.

Similarly, we could construct scenarios for different provider types, considering varying levels of efficiency achieved. This analysis may potentially offer greater insight on the materiality of the impacts across providers, but will depend on the availability of robust financial data at individual provider level.

Figure 5: Scenario analysis; financial performance of providers measured by their operating margins[20] – illustrative example



Patient level impacts

In the autumn IA we will consider qualitatively the impacts on patients of reduced tariff volatility and the cost uplift and efficiency adjustments to tariff, following the provider impact analysis. As discussed earlier, primary research into the relationship between tariff and quality is currently limited in health care; which will restrict this assessment.

As a first step to move closer to understanding patient level impacts, we propose that the provider level impact analysis, where possible, is disaggregated across a number of different service areas. This disaggregation will help to identify which areas of service provision could be more greatly impacted. For the autumn IA, the service areas which are likely to be available for consideration include:

i. outpatient attendances;

ii. outpatient procedures;

[20] Operating margins exclude capital expenditure investments in property plant and equipment and therefore do not reflect the full economic costs of providing services. Positive operating margins are used to make investments which ensure the continued future provision of high quality healthcare services. Real reductions in providers' operating margins will reduce their ability to reinvest for the future.

iii. admitted patient care – elective/day care;

iv. admitted patient care – non-elective; and

v. accident and emergency.

The analysis we propose to conduct for the autumn IA will therefore include the following:

U1. **Quality.** Should large changes in provider viability be identified, a qualitative consideration may be required to understand any potential incentives for changes to service quality.

U2. **Choice.** The IA will qualitatively consider the impact on patient choice. This discussion will flow through from the appraisal of the providers' financial position (so far as this has been possible) for different service categories as discussed above.

DQ19 Do you agree with the proposed analysis to consider cost uplift and efficiency impacts for the autumn 2013 impact assessment?

DQ20 Is there additional evidence, data or information we could consider for the autumn 2013 impact assessment analysis of cost uplift and efficiency impacts? Please provide details.

A6 Impact assessment – impacts of specific HRG and tariff adjustments

This section covers the impact assessment work that we have undertaken to date regarding the impacts of a limited number of specific HRG and tariff changes. Our work assesses the impact of the proposed specific adjustments on providers.

The impacts of the following adjustments have been assessed and a quantification of these impacts is included in Section A6.4.

Adjustments assessed

- HRGs design changes (new tariffs for 2014/15):
    - laparoscopic/open kidney and ureter procedures.
- Tariff changes to correct HRG issues:
    - major IR hepatobiliary procedures RC31Z.
- HRG logic changes to correct tariffs:
    - spinal surgery HC02/HR02; and
    - electroencephalograph telemetry AA34C/AA34D.
- Design changes for 2014/15 (no tariff change):
    - physical abuse / trauma;
    - stapled transanal rectal resection for obstructed defecation syndrome; and
    - fractional flow reserve.

The specific adjustments will change a very limited number of prices in the NTD and their impact on providers, commissioners and therefore, on patients, is limited at a total quantum level (the level of costs at a national level).

Adjustments not yet assessed

For some areas we have not yet been able to assess the impact of adjustments on providers. Please refer to Section A3.2 for a list of these along with reasons for omission and, so far as possible, our initial estimated scale of impact at a national level.

For the assessment not yet conducted but expected for the autumn IA, we believe that the impacts are likely to be minimal due to a low number of spells and/or very small changes in tariffs. An exception to this is the change in tariff sharing for maternity pathways although these are not mandatory until 2015/16.

A6.1 Impact assessment quantitative methodology

This Impact Assessment assesses the impact of the proposed specific adjustments to tariff prices on NHS providers. As such, it applies two sets of prices (in this case the 2013/14 published and 2014/15 proposed tariffs) to a constant activity set.

The Market Forces Factor (the appropriate payment MFF) has been applied accordingly to the estimated income.

All figures are in 2013/14 prices (i.e. the 2014/15 proposed tariffs are calculated before cost uplift and efficiency adjustments for CNST, PFI, service enhancement, inflation and efficiency have been applied).

The IA includes all structural elements of the tariff (e.g. excess bed days and the short-stay emergency tariff), but does not cover variations and rules such as the 30% marginal rate and non-payment for emergency readmissions[21].

The IA is based on like-for-like tariff scope, and covers admitted patient care, outpatients (including unbundled diagnostic imaging) and A&E. Where appropriate underpinning data at provider level is available, we have incorporated best practice tariffs into the analysis.

Base activity

The same activity has been used in both years to ensure income is comparable. Table 5 sets out the activity and price data that has been used:

[21] The exception is specialist top-ups, which is considered a local variation and is included in the impact assessment.

Table 5: Activity and price data used in specific HRG and tariff change Impact Assessment

	Activity Data	2013/14 Tariff Prices	2014/15 Tariff Prices
Admitted Patient Care	2011-12 HES	2013/14 Published Tariff	2014/15 Proposed Tariff
Outpatient Procedures[22]	2011/12 reference costs		
Outpatient Attendances			
Accident & Emergency[23]			
Unbundled diagnostic imaging (in outpatients)			

Grouper

Daycase, elective and non-elective activity comes from running the latest nationally available activity data (2011/12 HES) through the 2013/14 local payment grouper. In some cases it was necessary to use data from other sources as outlined in the detailed sections below.

Exclusions

Service exclusions have been applied to the HES activity data at Finished Consultant Episode (FCE) and spell level, as per existing PbR guidance. However, in most cases we have not applied procedure (and other) exclusions done at diagnosis and procedure level.

Spell truncation and lengths of stay

The 2011/12 HES data used only includes spells which end within the financial year. FCEs which end prior to the start of 2011/12, but form part of a spell ending in 2011-12, have been omitted from the data, as have any FCEs which form part of open spells at the end of the year. Spells length of stays have been limited to a start date of 1 April 2011.

[22] Where outpatient procedures are recorded in reference costs against HRGs without a mandatory outpatient procedure tariff, activity has been mapped through to treatment function level and the relevant outpatient attendance price has been applied.

[23] In line with how the tariff for A&E operates, the following recoding has been made to the reference costs data:

- data supplied by PCTs, as well as that recorded as Minor Injury Unit (MIU) or non-24 hour has been recoded to HRG VB11Z; and
- data submitted as Dead on Arrival (DOA) has been recoded to HRG VB09Z to reflect a minimal cost intervention.

A6.2 Specific elements of Impact Assessment methodology

The principles of the approach to our Impact Assessment are consistent across all areas of specific price changes, however, the grouped activity data was not always available to underpin our analysis. For a number of the specific adjustments, additional activity data to underpin the IA was required by us and we had to make a number of assumptions.

The activity data used was run through a number of payment and reference cost groupers and, where possible, we used the following approach:

(a) identification of data through relevant procedure, diagnosis and HRG codes; and either
(b) use of appropriate grouper outputs in the place of those for 2013-14 local payment grouper; or
(c) manually grouped.

A more detailed description of our methodology, for specific changes, is set out below:

- design changes for 2014/15 (no tariff change):
    - physical abuse / trauma;

      activity was manually grouped, due to very low levels of activity, where ICD-10 code (a diagnosis code) T741 was reported;

    - stapled transanal rectal resection for obstructed defecation syndrome;

      activity was identified where OPCS codes (procedure codes) H412 and Y263 are reported in combination. HRG was mapped from FZ50Z using the 2012-13 reference grouper, where FZ77D/E are equivalent to FZ11A/B respectively;

    - fractional flow reserve;

      activity was identified where procedure code of K518 in any position and K634, K635 or K636 as spell dominant procedure. Revised (2014-15) HRG was set to EA35Z;

- new tariffs for 2014/15;
    - laparoscopic/open kidney and ureter procedures;

      the impact was calculated as the difference between income under 2013-14 local payment grouper and 2011-12 reference costs grouper, where activity is grouped to HRGs LB60 – LB63 under the reference costs spell HRG;

- issues raised with 2013/14 tariffs;
    - major interventional radiology hepatobiliary procedures;

      the impact reflects a change in price between 2013-14 and the proposed tariff for 2014-15;

- spinal surgery;

  activity was identified where the spell dominant procedure is V402 to 4 in combination with ICD-10 codes for tumour and deformity. Using a 2013-14 local payment grouper, activity grouping to HC02 and HC01 has been mapped to HR02Z and HR01 respectively. For activity in HC01, the split between HR01A and HR01B (with and without CC) was based on the national split of activity;

- electroencephalograph telemetry;

  for activity with a spell dominant procedure of U221, output from the 2012-13 local payment grouper was applied. However, this logic did not include the subsequent design change to differentiate HRGs within sub-chapter AA to with and without CC so, for example, some activity initially mapped to AA21Z rather than AA21A or AA21B. We split activity between the respective HRGs based on the division of national activity between the two.

DQ 21. Do you agree with the approach described to assess the impact of specific price changes?

If no, please suggest alternative approaches along with your rationale.

A6.3 Impact Assessment calculation

To determine the absolute and percentage variations in tariff incomes on acute providers, we made the calculations set out below.

By acute provider we took:

Activity data 2011-12 * 2013-14 published tariff prices * MFF

= Provider tariff income based on 2013/14 tariffs **(A)**

We did a similar calculation but using proposed 2014/15 tariffs:

Activity data 2011-12 * 2014-15 proposed tariff prices * MFF

= Provider tariff income based on proposed 2014/15 tariffs **(B)**

We then calculated the absolute change in tariff income by provider:

B – A = absolute change in tariff income from 2013/14 to 2014/15 at constant 2011/12 activity levels

We calculated the percentage change in tariff income by provider using the following formula:

(B – A) / A * 100 = percentage change in tariff income from 2013/14 to 2014/15.

We now had the change in tariff income by provider. To produce Table 6 below, we took the maximum and minimum of the tariff income changes across (mostly) acute providers. To derive the average tariff income change (in absolute and percentage terms), we took the unweighted arithmetic mean of the tariff income changes across all acute providers.

A6.4 Output of Impact Assessment – providers

Results of our Impact Assessment for 161 (mostly) acute providers are set out in Table 6 below.

Table 6: 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[24]		Due to HRG design changes[25]	
	£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%*

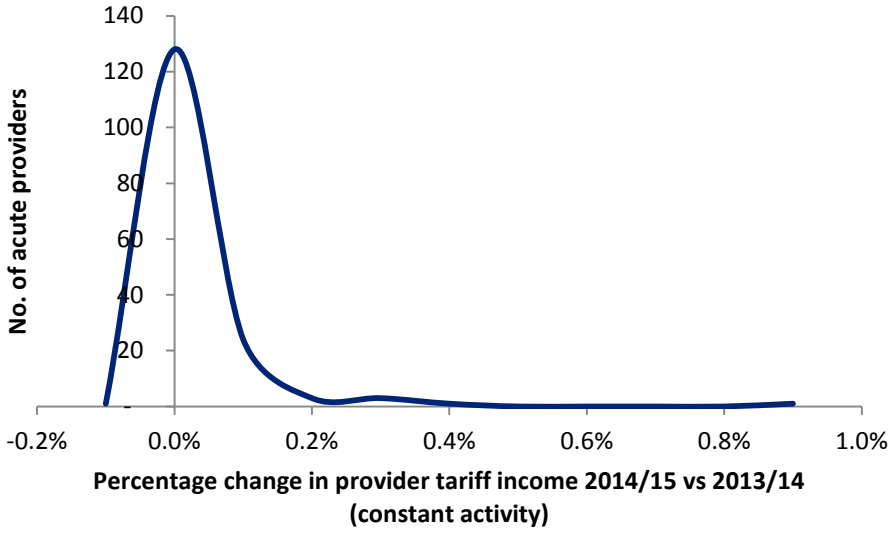
The figures above tell us that overall, the largest increase to provider tariff income resulting from changes to prices and HRG changes described above is an increase of 0.9% compared with 2013/14 published tariffs based on 2011/12 activity data. The largest decrease in a provider's tariff income is 0.1%. Of this, changes to HRG design account for a larger change than changes in prices. Note that the maximum and minimum figures above are not cumulative as they may apply to different providers.

We have looked at 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. The largest reduction in tariff income experienced by any provider amounts to about 0.1% of its projected 2013/14 tariff income. A few providers are expected to experience small rises in tariff income with one provider expected to see a 0.9% increase in its tariff income. Figure 6 below shows a graphical distribution of the results of our analysis.

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

[25] 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

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



On the basis of our analysis, we believe that the impact of the specific HRG and tariff changes for which we have so far been able to conduct a quantitative analysis (listed at the beginning of this chapter) is marginal so far as provider tariff income is concerned. As can be seen in Figure 6 above, most acute providers will 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).

A6.5 Output of Impact Assessment – commissioners

We have not yet assessed the impacts of the proposed price changes and HRG design changes on commissioner affordability. This is due to the split of commissioning of services between CCGs and NHS England. We do not currently have data to separate out NHS England and CCG commissioning. Any commissioner IA should exclude each CCG's share of specialist commissioning. Until we have this split of commissioning costs, any CCG IA will be of limited value. We expect to have the split of commissioning data to allow an IA at commissioner level to be carried out for the full IA in the autumn. We anticipate that the format and presentation of the commissioner affordability analysis will be similar to that described in Table 6 above for providers.

A6.6 Impact assessment planned for the autumn

Provider impacts

As at June 2013, we are in a position where a number of key decisions are yet to be made or data is required before a full IA can be conducted. These areas are set out in Section 3.2. For the autumn IA, we will carry out the analysis proposed using the latest publicly available data. We are already working to obtain data identified as necessary for the quantitative analysis of some of the areas listed in Section 3.2.

Commissioner impacts

As mentioned in section A6.5, once we have commissioning data split by specialist NHS England and CCG commissioning, we will map providers to CCGs and conduct a quantitative assessment of impacts of the price and HRG changes on affordability of commissioners.

Setting price, HRG and policy changes in context

The assessment presented in this section considers the absolute and percentage change in tariff income for providers. We would like to expand this analysis to consider the size of these impacts in the context of the financial position and viability of each provider. This will increase the meaningfulness of the analysis substantially. To perform this analysis we will need to have full NHS trust FIMS data and foundation trust equivalent financial data. We are currently in the process of trying to obtain this so that it may be used in a timely manner for our assessment in the autumn.

Likewise, for commissioners, we wish to set the impacts of changes in affordability of commissioners in the context of their budgetary allocations.

Direct and indirect impacts

The assessment described above considers only direct impacts from a change in prices of new HRG groupings. These changes may lead to changes in behaviour on the part of providers who may find that maintaining the current supply of services leads to greater surpluses or deficits, dependent on the price and HRG changes or changes to local variations and rules. Likewise, commissioners may also alter their purchasing behaviour as a result of these price and HRG changes or changes to local variations and rules. We have made no attempt so far to estimate these behavioural changes. In the work to be conducted for the autumn IA, we may run a number of “what if” scenarios focussed on areas where we expect the changes described to affect provider and/or commissioner behaviour to a significant degree. We propose to use sensitivity analysis to produce any “what if” scenarios.

DQ22. Do you have suggestions for any other assessment we could conduct in the autumn IA (or beyond)? If yes, please describe this assessment including a description of the data that would be required and whether you already collect and report this data.

A7 Impact assessment – impacts of other adjustments

A number of other policy development areas have been set out in Sections 4, 5 and 6 of the Engagement Document, namely Local Modifications, variations and rules and enforcement. Using the impacts framework described in Section A4.2 above, we have carried out an initial qualitative assessment of the impacts of each of these on the three stakeholder groups, namely: patients, commissioners and providers.

We will seek to increase the depth of this analysis in the autumn IA. In addition to identifying and describing impacts, we may seek to quantify or partially quantify them where available evidence and data allows this.

A7.1 Impact of Local Modifications

Context

The Act creates a new framework to allow prices to be modified where local circumstances make it uneconomic to provide the services in question at the price determined in accordance with the national tariff. A key principle guiding our policy in this area is that Local Modifications should only be approved for providers where they face a structural cost difference that is beyond their control. There are two types of Local Modifications, agreements and applications. Providers and commissioners can agree a local modification and submit it to Monitor for approval. Alternatively, if providers and commissioners are unable to reach agreement, a provider can submit a local modification application to Monitor, subject to a number of conditions. Further details on Local Modifications and how we propose to apply them, can be found in section 5 of the Engagement Document.

Counterfactual position

We have considered the impact of the introduction of Local Modifications versus a counterfactual scenario of no Local Modifications, i.e. the current operating scenario. However, we note that providers facing financial distress may have previously received non-recurrent income or additional funding from commissioners or the Department of Health. It is important to consider this when assessing the incremental impact of Local Modifications.

Preliminary commissioner level impacts from Local Modifications

Affordability

We consider the potential impact of local modification agreements and applications on commissioner affordability.

Agreements

In a local modification agreement, providers and commissioners mutually agree on the structural issue that a provider faces and the proposed modification to the prices determined by the national tariff ("the national

tariff price"). As such, the commissioner is likely to have regard to its overall budget and affordability issues when agreeing a local modification. This may limit the impact of local modification agreements on affordability. However, we are still considering how agreements would apply in cases where a provider provides the same services to multiple commissioners, but only some of those commissioners are willing to agree to a local modification. This will affect the impact that Local Modifications have on affordability.

Applications

In the event that a provider and commissioner cannot agree a local modification agreement, a provider may submit a local modification application to Monitor. If we determine that a local modification is appropriate, this could potentially impact on commissioner affordability as commissioners will be required to provide additional funding to the provider. However, there are a number of proposed mechanisms to limit this impact, for example:

- the total value of a local modification will be limited to the lesser of the overall deficit for the provider or its overall deficit on national tariff services;
- Local modifications will only be used to fund structural cost differences, they cannot be used to fund provider inefficiency; and
- in most cases, local modification applications will become effective at the start of the following financial year, enabling Clinical Commissioning Groups and NHS England to adjust budget allocations accordingly.

Preliminary provider level impacts from local modifications

Financial viability

Local modifications could improve the financial viability of providers that face structural cost differences which are not accounted for by the national tariff, and that are otherwise at risk of failing. Obtaining a local modification could therefore reduce the number of providers entering the failure regime. However, the magnitude of this impact depends upon the current level of additional funding (for example, non-recurring income) that these providers receive.

Additionally, the evidence requirements for both agreements and applications may incentivise provider efficiency and thus promote financial viability. Providers and commissioners must submit evidence to demonstrate the reasonably efficient cost of providing the affected service (i.e. the service to which a local modification would apply). Whilst providers may receive additional funding through other mechanisms in the current scenario, the evidence requirements on Local Modifications introduce additional transparency into this process and may therefore support improved financial performance.

Preliminary patient level impacts from Local Modifications

Patient choice

Local modifications could potentially impact upon patient choice. In particular, if commissioners face financial pressure as a result of Local Modifications, this could reduce the volume of services commissioned, thereby reducing patient choice in a local health economy. However, as discussed above, this is unlikely to be the case for agreements and there are a number of mechanisms in place to limit the impact of applications on commissioner affordability.

Additionally, by promoting financial viability for providers that might otherwise fail, Local Modifications could have a positive impact on patient choice, versus the counterfactual scenario. As above, the magnitude of this impact depends on the financial support that distressed providers receive in the counterfactual scenario.

Quality

Certain providers may not be able to provide services of an acceptable quality due to the structural cost differences they face. Local modifications could enable these providers to provide the affected services at an acceptable quality, therefore improving quality and patient outcomes at the affected provider.

However, where services are of an acceptable level (as determined by commissioners and relevant quality standards), Local Modifications are not the appropriate mechanism to pay for increased quality[26]. As such, the impact of Local Modifications on providers that are already providing services of an acceptable quality is likely to be limited.

A7.2 Impact of variations and rules

Context

Section 116 of the Act states that the NTD may include five main types of rules and variations:

1. National variations to national prices;

2. Local variation rules to regulated national prices and mandated currencies (formerly known as ‘flexibilities’);

3. Rules under which providers and commissioners can make modifications to national prices;

4. Rules for local price setting, where no national currency and price is specified (see section 3 of the Engagement Document); and

[26] Providers and commissioners can consider local payment variations to national prices and currencies where they would like to re-design clinical pathways and payment terms in order to provide a higher quality service.

5. Rules for making payments.

A number of subcategories exist within each of the categories above. These subcategories are listed in the table below along with a description as to whether they will be covered in the autumn IA or if not, explaining the reason for their exclusion.

Table 7: Variations and rules – proposed Impact Assessment for the autumn IA

Variations and rules	autumn IA (Y/N)	Level of assessment
National variations to national prices		
MFF	Y - no change	Not applicable
Specialist top ups	Y - no change	Not applicable
30 day readmission rule	N - no change	Not applicable
Maternity pathway tariff sharing of gains losses	Y	Describe/partially quantify
Unbundled diagnostic imaging in outpatients - flexibility to share financial surpluses and deficits between providers and commissioners	TBC	TBC
30% marginal rate rule for emergency admissions	TBC - dependent on policy decision	TBC
External beam radiotherapy and chemotherapy delivery, move fully to national prices	TBC - dependent on policy decision	TBC
Local variation rules to regulated national prices and mandated currencies		
Local payment variations (discussion document)	TBC	Describe
Rules allowing modifications to national prices		
Local modifications	Y	Describe/partially quantify
Rules for setting prices where no national price is set in the national tariff		
Rules for reimbursement of other acute services	N - roll forward tariffs	Not applicable
Rules for reimbursement of mental health	TBC	Describe
Rules for the reimbursement of ambulance and transport services	TBC	TBC
Rules for reimbursement of other out of hospital services	N - only guidance for 2014/15	Not applicable
Rules for reimbursement relating to quality and safety standards	TBC	Describe
Rules for making payments		
None	n/a	n/a

Impact assessment will help inform policy development going forward and where policy decisions result in a change from the status quo, to the extent that we have data allowing quantitative assessment, we will look to at least partially quantify impacts on providers, commissioners and patients. Where data is not sufficient for quantification, we will identify and describe the expected impacts in the autumn IA.

A7.3 Impact of enforcement

Context

An enforcement regime existed under the PbR system allowing the DH to take action against commissioners or providers who failed to abide by the national tariff prices. According to the 2012 report, *"An evaluation of the reimbursement system for NHS-funded care"* commissioned by us from PwC, there is no *"evidence of examples where non-compliance with PbR rules was investigated and dealt with under sanctions available."*

The inclusion of enforcement of a national tariff for health care services in sections 115 – 117 of the Act and the inclusion of an enforcement mechanism in the licence conditions of licensed providers would seem to be, for all intents and purposes, like a new mechanism.

In such a context, the new proposals for enforcement of the NT may be seen as an unwelcome additional burden on commissioners and providers. In reality, enforcement is one mechanism in the new regulatory operating model of encouraging use of national tariffs, or where this is not feasible, of ensuring that commissioners and providers use the suite of tools available to them in this new regulatory operating model to agree prices in a transparent way, allowing us to understand both the agreements reached and the considerations used in reaching agreement. The information available to us from this increased transparency should help us to set national tariffs and to define currencies that better reflect the operating constraints and realities of commissioners and providers and hence allow us to set tariffs that will in the future, reduce the need for individual agreements.

Counterfactual position

In an earlier IA conducted for us by PwC and published in September 2012, we assessed the impacts of an enforcement mechanism that formed part of the licence conditions of licensed providers versus a counterfactual of having an enforcement regime mandated by the Act. We can use a variety of methods to enforce the NT. These range from informal to formal powers. Formal powers relating to commissioners include:

- directing a commissioner to correct a non-compliant situation.

Formal powers relating to providers include:

- agreeing an enforcement undertaking with a provider;
- imposing a discretionary requirement on a provider (including a financial penalty);
- imposing an additional licence condition on a foundation trust; and
- revoking a provider's licence.

Informal action does not involve using our formal powers. It may include letters, phone calls, education and workshops. Even when a matter could be addressed by using formal enforcement powers, we may

consider it appropriate to deal with the matter informally and give providers and commissioners an opportunity to address any non-compliance issue without a formal investigation.

Our counterfactual position is the use of formal enforcement methods. The use of informal enforcement methods is compared against this in this preliminary IA.

The impacts are summarised below.

Preliminary commissioner level impacts from enforcement

Affordability

Enforcement is designed to encourage commissioners to conclude agreements with providers within the new regulatory operating model allowing us to capture data about these agreements. Costs may be slightly higher in the first 1 or 2 years while commissioners become familiar with the new enforcement mechanism and how to comply with it. This may involve some additional FTE resourcing or occasional use of consultants. However, we would expect that these same costs would be incurred by commissioners in the counterfactual situation with a formal enforcement mechanism. We do not expect the cost of complying to have any major negative impact on overall commissioner affordability. In the long term, it should increase affordability as fewer variations away from national prices are required and/or as commissioners become familiar working within the enforcement framework whichever enforcement mechanism is ultimately used.

Should investigations reveal that there has been non-compliance with the national tariff, it is hard to determine whether an informal enforcement regime would lead to increased compliance costs for commissioners versus the counterfactual. We need to consider the informal actions taken versus the cost to the commissioner of having to correct a non-compliant situation. In the longer term, informal enforcement involving education of commissioners should reduce the number of agreements deemed non-compliant. Fewer non-compliant agreements should lead to better value for money for commissioners, improving affordability. A formal enforcement approach might be less helpful in providing commissioners with the knowledge required to determine for themselves the extent to which compliance is or is not being achieved and would thus delay the benefits that higher compliance has on affordability.

Preliminary provider level impacts from enforcement

Financial viability

As for commissioners above, costs of compliance may be slightly higher in the first 1 or 2 years while providers become familiar with the new enforcement mechanism and how to comply with it irrespective of the enforcement mechanism used, formal or informal. We do not expect cost of complying to have any major negative impact on overall provider viability. In the long term, it should increase viability as fewer variations away from national prices are required (due to national tariffs reflecting the realities of service provision) and/or as providers become familiar working within the enforcement framework irrespective of the enforcement mechanism used.

If enforcement revealed non-compliance with national tariffs, compared with some sanctions available under the counterfactual, we would expect an informal enforcement approach to have a lower cost on

providers in most instances leading to improved financial viability. In the longer term, the educative informal enforcement approach should result in providers being able to better self regulate and avoid non-compliance compared to the counterfactual. This should lead to fewer non-compliant incidences and reinforce the financial viability of such providers and enable efficient providers to deliver better outcomes for patients.

Preliminary patient level impacts from enforcement

Quality

In the short term, the additional costs for commissioners and providers should be small enough to have no discernible impact on patients. This is the case largely independent of the enforcement mechanism used, formal or informal. In the longer term, better self regulation which is more likely to be achieved through informal enforcement should mean greater stability and financial viability for providers leading to marginally better quality for patients although this impact is likely to be difficult to measure.

To the extent that pricing becomes more compliant with the national tariff through enforcement, this will lead to improved quality for patients as commissioners will get better value for money from their providers.

It is likely to be difficult to quantify the impacts described in this section. However, we will seek to conduct a more in-depth assessment for the autumn IA.

APPENDIX B – Summary of proposed conditions for local modification agreement

This appendix summarises the conditions that Monitor is proposing for local modification agreements and applications and provides a high-level overview of the type of supporting evidence that Monitor would expect providers and commissioners to submit for each condition. The proposed mandatory submission requirements presented in this Appendix are not final or exhaustive. Monitor may request additional evidence from providers and commissioners on a case-by-case basis, for both agreements and applications. Monitor is still developing its methodology for assessing local modifications and we plan to publish further details on supporting evidence when we publish guidance for informal stakeholder engagement later this year.

Agreements

Table B-1 below presents our proposed mandatory submission requirements for providers and commissioners when submitting an agreement. We propose that each condition will be supported by pro-forma templates that specify the information which providers and commissioners must provide. Additionally, we propose that this information would be supplemented with joint self-certification declarations signed by both the provider and commissioner. Monitor would take a proportionate and risk-based approach to assessing agreements. We would not, however, rely solely on self-certification and assurance. Monitor must be satisfied that, without a local modification, the service is uneconomic.

Applications

Table B-2 below presents our proposed mandatory submission requirements for providers when submitting a local modification application. Whilst application submissions are made by providers, Monitor would also engage with relevant commissioners in order to understand any specific structural issues in the local healthcare economy and commissioners would also have an opportunity to present arguments and evidence on why a local modification should not be approved.

Table B-1: Proposed policy conditions and supporting evidence for agreements

Proposed policy condition	**Proposed information to be provided by providers and commissioners as part of mandatory submission when submitting a local modification agreement to Monitor for approval**
1. The provider and commissioner agree and can provide supporting evidence that, without a local modification, it would be uneconomic, based on the criteria set by Monitor, for the provider to provide specific NHS services at the prices determined by the National Tariff.	• For each service that would be affected by the proposed local modification, the following information, and any relevant supporting evidence, should be provided: – The current National Tariff prices that apply to the services, taking into account and explaining all applicable variations. – The proposed amendments to the prices. – Confirmation from the provider and commissioner that it would be uneconomic to provide the services without a local modification, including an explanation of the structural cost difference faced by the provider. – Confirmation from the provider and commissioner that the identified structural cost difference is non-controllable and not reflected in existing variations to National Tariff prices. • The provider's overall materiality and quality score (MAQS) for cost allocation or other evidence of the reliability of its cost allocation processes.
2. The provider and commissioner have considered alternative means of providing the services and are satisfied that the relevant services cannot be provided at the National Tariff price while still providing a reasonable quality of patient care.	• An explanation of the alternative options that the provider and commissioner have considered for the services that would be affected by the proposed local modification, along with supporting evidence.
3. The provider and commissioner agree and can provide supporting evidence that the proposed modification reflects a reasonably efficient level of cost, given the structural differences faced by the provider, and that the services are of a reasonable quality (or would be if the modification was approved).	• Confirmation and supporting evidence from the provider and commissioner that the proposed local modification reflects a reasonably efficient level of cost, given the structural differences faced by the provider. Supporting evidence could include benchmarking analysis to demonstrate that the provider is reasonably efficient compared to an appropriately defined comparator set. • Confirmation from the provider and commissioner that services affected by the proposed local modification are of an acceptable quality and meet the minimum CQC quality standards.

Table B-2: Proposed policy conditions and supporting evidence for applications

Proposed policy condition	**Proposed mandatory submission requirements from providers making local modification applications**
1. The applicant provider must identify the specific NHS services requested by the commissioner which are uneconomic for it to provide at the National Tariff price, based on the criteria set by Monitor.	• Details of the services that would be affected by the proposed local modification, the current prices that apply to those services (after taking into account all applicable variations), and the expected volume of activity.
2. The applicant provider must be able to demonstrate that it has sought to agree a local modification with the commissioner and has considered alternative means of providing the services at the National Tariff price.	• Evidence that the provider has sought to engage constructively with relevant commissioners including details of the alternative options that the provider and commissioners have considered for the services that would be affected by the proposed local modification.
3. The applicant provider must not be able to cease to provide the services for which the local modification is requested.	• Evidence confirming that the services that would be affected by the proposed local modification are designated as Commissioner Requested Services; or other evidence to confirm that the services are requested by the relevant commissioners; or evidence there are other reasons that the provider cannot cease to provide the services.
4. The applicant provider must have a sustained and on-going deficit at an organisation level and on National Tariff services overall.	*Note: the dates below are based on a provider making a local modification application in 2014/15.* • Evidence of deficit at an organisation level and on National Tariff services overall in 2013/14. • Full year forecast outturn (2014/15) and current trading results. • Financial plans for 2015/16. • Details of normalising adjustments, including, for example, how exceptional items and non-recurring income or expenditure have been removed from the submitted figures.

5. The applicant provider must provide evidence to demonstrate that the deficit on National Tariff services is driven by structural differences in the provider's costs, which are not already reasonably reflected in the National Tariff prices, rules or variations.	• For each service that would be affected by the proposed local modification, the following information, and any relevant supporting evidence, would be requested: – Detailed information on costs and revenues. – Confirmation from the provider that it would be uneconomic to provide these services without a local modification along with an explanation of the structural cost difference faced by the provider. – Confirmation from the provider that the identified structural cost difference is non-controllable and not reflected in existing variations to National Tariff prices. • The provider's overall materiality and quality score (MAQS) for cost allocation or other evidence of the reliability of its cost allocation processes.
6. The applicant provider must propose a modification to the National Tariff prices of the services and provide evidence to show that the proposed modifications reflect a reasonably efficient level of cost, given the structural differences faced by the provider, and that the services are of a reasonable quality (or would be if the modification was approved).	• The proposed modifications to the National Tariff prices for each service that would be affected by the proposed local modification. • Benchmarking analysis against an appropriate comparator set with similar structural costs, in order to demonstrate a reasonably efficient level of cost for providing the service. • Details of how the provider has reviewed efficiency as part of its monitoring of financial performance and an explanation of how the proposed price takes account of any known inefficiency, if appropriate. • Confirmation from the provider that the services affected by the proposed local modification are of the quality required by the commissioner and meet minimum CQC quality standards.

Appendix C – Details of proposed currency changes

In Section 3.2, we proposed that the 2014/15 tariff would introduce (minor) updates where necessary to support clinical development.

In this Appendix, we set out those tariff changes in more detail. These details include the description of the services that are subject to tariff updates, and a brief summary of the reasons for each update.

Unless stated otherwise, the HRG changes described in this Appendix will appear in the Engagement Grouper (that we are releasing alongside this Engagement Document)[27].

New HRGs for laparoscopic and open kidney and ureter procedures

We propose to change the design of kidney and ureter HRGs to better reflect the relative costs of laparoscopic and open procedures. The change also better recognises the resources involved in carrying out more than one procedure at a time.

This proposed change would remove six HRGs and introduce eight new HRGs. It also allocates some procedure codes from other HRGs into the eight new HRGs, as part of recognising the costs of doing more than one procedure at a time.

We propose to introduce prices for the eight new HRGs. Although in principle the prices for other affected HRGs should be changed (for example, where some activity moves to one of the new eight HRGs to reflect multiple procedures), we propose to not do this for 2014/15 because the cost data that we have does not fully reflect the HRG design changes.

The following six HRGs have been deleted:

LB02A	Kidney Major Open Procedure 19 years and over with Major CC
LB02B	Kidney Major Open Procedure 19 years and over with Intermediate CC
LB02C	Kidney Major Open Procedure 19 years and over without CC
LB02D	Kidney Major Open Procedure 18 years and under
LB03Z	Laparoscopic Operations on Kidney and Ureter
LB07Z	Ureter Open Procedure

The following eight HRGs have been added:

[27] For more details and/or to download the Grouper, please see: http://www.hscic.gov.uk/casemix/downloads

LB60A	Complex Open or Laparoscopic Kidney or Ureter Procedures with Major CC
LB60B	Complex Open or Laparoscopic Kidney or Ureter Procedures without Major CC
LB61A	Major Open Kidney or Ureter Procedures 19 years and over with Major CC
LB61B	Major Open Kidney or Ureter Procedures 19 years and over without Major CC
LB62A	Major Laparoscopic Kidney or Ureter Procedures 19 years and over with CC
LB62B	Major Laparoscopic Kidney or Ureter Procedures 19 years and over without CC
LB63A	Major Open or Laparoscopic Kidney or Ureter Procedures 18 years and under with CC
LB63B	Major Open or Laparoscopic Kidney or Ureter Procedures 18 years and under without CC

New HRG for complex therapeutic endoscopy

Complex therapeutic endoscopy is a set of procedures that are not appropriately reimbursed in the 2013/14 tariff.

We propose to introduce a new HRG[28] for complex therapeutic endoscopies. Activity for this HRG can be identified using combinations of procedure codes. The majority of the activity that will go to the new HRG was previously mapped to HRGs FZ24A/B/C/D (Major Therapeutic Open or Endoscopic Procedures).

We propose to publish a price for this new HRG as part of the autumn consultation.

New HRG for complex bronchoscopy

Complex bronchoscopy is another set of procedures that are not appropriately reimbursed in the 2013/14 tariff.

We propose to introduce a new HRG[29] for complex bronchoscopy. Activity for this HRG is identified using combinations of procedure codes. The majority of the activity that will go to the new HRG was previously mapped to HRGs DZ07A/B (Fibre Optic Bronchoscopy) and DZ17A/B/C (Respiratory Neoplasms).

We propose to publish a price for this new HRG as part of the autumn consultation.

[28] FZ89Z

[29] DZ54Z

New HRGs for dialysis for acute kidney injury

Dialysis for acute kidney injury is not currently identified by HRGs, and will be associated with activity in many different HRGs. We propose to change the design of HRGs to help providers and commissioners better identify and discuss dialysis for acute kidney injury.

The proposed change is to introduce four new HRGs[30] for dialysis for acute kidney injury. Activity for these HRGs can be identified using combinations of procedure and diagnosis codes. These HRGs are "unbundled" HRGs, i.e. they are generated in addition to an HRG for the core activity for the patient. One HRG will be generated for each session of dialysis.

We do not propose to set prices for these new HRGs for 2014/15, since these activities are outside the scope of the National Tariff, but we are mandating the use of these new currencies.

New HRG design for stapled transanal rectal resection for obstructed defecation syndrome (STARR)

STARR is a complex procedure that is not appropriately reimbursed in the 2013/14 tariff.

We propose to move activity for the STARR procedure to HRGs FZ11A/B (Large Intestine - Major Procedures). Activity for STARR can be identified using a combination of procedure codes. The majority of this activity previously mapped to HRG FZ50Z (Intermediate Large Intestine Procedures 19 years and over).

New HRG design for fractional flow reserve (FFR)

FFR (a heart procedure) is not appropriately reimbursed in the 2013/14 tariff when used with arteriography.

We propose to move activity using the FFR approach, when used with arteriography, to HRG EA35Z (Other Percutaneous Interventions). Activity using the FFR approach with arteriography can be identified using a combination of procedure codes, and reflects new coding guidance for coding FFR. The majority of this activity previously mapped to HRGs EA36A/B (Catheter).

[30] LE01A, LE01B, LE02A and LE02B

New HRG design to recognise coding of physical abuse in orthopaedics

There is an anomaly in relation to the way in which the ICD10 (diagnosis) codes for physical abuse are treated within the orthopaedic HRG chapter. This is being corrected for 2014/15 to ensure that the coded activity groups to the appropriate HRG. This affects a very small amount of activity, and is not concentrated in any given HRG.

New HRG design for spinal surgery for posterior instrumented spinal instrumentations and decompressions for tumour and deformity

This set of spinal surgery procedures are not appropriately reimbursed in the 2013/14 tariff.

We propose to move activity for posterior instrumented spinal instrumentations and decompressions for tumour and deformity to HRGs HR02Z (Reconstruction Procedures Category 5). This activity can be identified using a combination of procedure codes for posterior instrumented spinal instrumentations and decompressions and diagnosis codes for tumour and deformity. The majority of this activity previously mapped to HRG HC02B/C (Extradural Spine Major 1).

This design change is **not** included in the Engagement Grouper, but will be included in the Consultation Grouper.

New HRG design for electroencephalograph telemetry

This complex procedure is not appropriately reimbursed in the 2013/14 tariff for certain conditions.

We propose to move activity for electroencephalograph telemetry back to other HRGs in chapter AA (largely AA20A/B and AA21A/B), by reinstating the HRG design for this activity that was in use for payment in 2012/13. In addition, the HRGs AA34C/D would be renamed to reflect the change in activity mapping to these HRGs. Activity for electroencephalograph telemetry is identified by a procedure code[31], and in 2013/14 maps to HRGs AA34C/D (Neurophysiological Operations).

This design change is **not** included in the Engagement Grouper, but will be included in the Consultation Grouper.

[31] OPCS4 code U221

New HRG design to discourage use of OPCS4 code X351 (Intravenous induction of labour)

We hope to improve compliance with coding guidance for this procedure. According to coding guidance, the procedure (OPCS4) code X351 should not be used.

We propose to map this procedure code to an HRG which attracts a zero tariff - UZ01Z (Data invalid for grouping). This affects a very small amount of activity, and is not concentrated in any given HRG.

New HRG design to discourage use of .8 and .9 codes from OPCS4 overflow chapters

The procedure (OPCS4[32]) codes ".8" and ".9" are for activity which is not specified by other procedure codes. For example, OPCS4 code A018 is for 'Other specified major excision of tissue of brain' and code A019 is for 'Unspecified major excision of tissue of brain'.

Where an OPCS4 chapter has become full, an overflow chapter is created. When this happens, any 'other specified' or 'unspecified' activity should be coded using the .8 and .9 codes from the original OPCS4 chapter, and not the overflow chapter.

To encourage the correct use of .8 and .9 codes (i.e. from the original OPCS4 chapter), we propose to map any activity using .8 and .9 codes from OPCS4 overflow chapters to HRG UZ01Z (Data invalid for grouping). This HRG has a zero tariff.

Although in principle the prices for affected HRGs should be changed, we will not do this for 2014/15.

Update to procedure codes

The latest upgrade to OPCS4, (which is called OPCS4.7), will be implemented in April 2014. This does not directly affect HRG design in 2014/15, as the new OPCS-4 codes will be mapped to existing OPCS-4 codes in the grouper software for 2014/15.

New BPT for Primary Hip and Knee Replacements

We propose to introduce a new BPT for primary hip and knee replacements to promote improved outcomes for patients. It would apply to all elective admissions to HRGs HB12B, HB12C, HB21B and HB21C. We propose that this BPT will replace the BPT for Primary Hip and Knee replacements set out by the PbR team in the 2013/14 PbR Guidance.

[32] OPCS4 is the "Office of Population Censuses and Surveys 4 for operations, procedures, and interventions.

Payment of the BPT would be conditional on criteria linked to data collected through The National Joint Registry (NJR) and Patient Reported Outcome Measures (PROMs). This BPT is our first step towards linking payment to outcomes achieved for patients. We believe that through linking payment more closely to what matters to patients, namely their outcomes and experiences of care, we can create incentives for a more consistent delivery of efficient and clinically effective care.

While many providers are adhering to the existing best practice criteria for total knee and hip replacements, this does not appear to be translating into reported benefits by patients. In particular, a small number of providers have levels of average health gains significantly lower than the national average, even after applying a case-mix adjustment. We would like to see these providers improve the quality of care they deliver for patients.

In addition, there are considerable differences in provider level compliance rates to both NJR and PROMs collections. Collecting data on quality through PROMs and clinical audits is important as these data underpin high quality care and can inform choices made by commissioners and patients, as well as policy development. By linking payment for the BPT to achieving minimum levels of compliance and consent rates we aim to improve data collection, submission and response rates.

The data collections are already well established and our proposal should not be overly burdensome. These collections contain all of the relevant information to help a commissioner identify whether a provider is achieving best practice.

We propose that payment of the BPT be conditional on two areas of best practice. Where these are not met providers would receive a non-best practice tariff. The criteria for payment of the BPT are:

1. The provider not having an average health gain significantly below the national average.

2. The provider must adhere to submission standards for quality data:

    (a) a minimum NJR compliance rate

    (b) a minimum NJR consent rate

    (c) a minimum PROMs response rate

Health gain will be measured by the condition specific Oxford Hip Score and Oxford Knee Score after applying a case-mix adjustment for primary joint replacement procedures only.

As the health gain is measured six months after surgery, there is a necessary time lag between PROMs collection and publication. To avoid delaying payment, commissioners should base payment on the latest available information at the time of payment. For 2014/15, in recognition that national PROMs data will relate largely to historical performance, we propose to introduce a rule for local variation to this national price, subject to commissioners' agreement. This local variation would allow providers, who are fully complying with the information submission requirements, but whose national PROMS scores are not above the national standard, to receive the best practice national price under certain circumstances. We are working with national clinical leaders to develop our detailed proposals for these circumstances and would welcome stakeholders' views

Amended BPT for Paediatric Diabetes

The paediatric diabetes BPT was introduced in 2012/13. Where providers can demonstrate that they meet 13 best practice standards set out in the 2013/14 PbR guidance, commissioners must pay a National Tariff covering a year of care for each child registered with the provider.

From 2014/15 we propose to expand the scope of the tariff to include inpatient care. Effective care of children with paediatric diabetes should minimise the need for patient admission. Including the expected costs of unavoidable patient admissions should further incentivise admission prevention.

Providers should no longer be reimbursed separately for admissions under the two HRGs PA67Z and PA68Z for children for whom they are receiving the increased best practice tariff. Please note that this does not include the admission at initial diagnosis of diabetes – these will continue to be reimbursed as normal. They will continue to be reimbursed:

- if registered children are admitted for another clinical reason; and
- for children who are not registered with them and for whom they are not receiving best practice tariff.

If these children are registered with another provider, the provider should invoice the provider with which the children are registered, for the inpatient care they give. If the information is not available the provider would invoice the relevant commissioner.

Amended BPT for Major Trauma

In 2014/15 we propose to change, and add to, the existing 2013/14 criteria for both Level 1 and 2 payments under the BPT for Major Trauma.

Although we propose that the criteria will change, we do not propose to change the 2013/14 price.

This proposal follows a recommendation from the Major Trauma Clinical Reference Group (CRG) that we should amend the criteria for best practice in order to continually improve quality of care for patients.

All Major Trauma Centres (MTCs), Levels 1 and 2, must meet the following criteria to receive the BPT:

- the patient is treated in an MTC;
- Trauma Audit and Research Network (TARN) data is completed and submitted within 25 days of discharge;
- rehabilitation prescription is completed for each patient and recorded on TARN;
- any coroners' cases are flagged within TARN as being subject to delay to allow later payment; and
- Tranexamic acid should be administered for those patients receiving blood products within three hours of arrival in the MTC.

A Level 1 BPT is payable for all patients with an Injury Severity Score (ISS) more than 8 providing that the following additional criteria are also met:

- If the patient is admitted directly to the MTC or transferred as an emergency, the patient must be received by a trauma team led by a consultant in the MTC < 30 minutes. The consultant can be from any specialty; or

- If the patient is transferred as a non-emergency they must be admitted to the major trauma centre within two calendar days of referral from Trauma Unit (TU). If there is any dispute around the timing of referral and arrival at the MTC this will be subject to local resolution.

A Level 2 BPT is payable for all patients with an ISS of 16 or more providing that the following additional criteria are also met:

- If the patient is admitted directly to the MTC or transferred as an emergency, the patient must be received by a trauma team led by a consultant in the MTC. The consultant can be from any specialty, but must be present within five minutes; or

- If the patient is transferred as a non-emergency they must be admitted to the major trauma centre within two calendar days of referral from Trauma Unit (TU). If there is any dispute around the timing of referral and arrival at the MTC this will be subject to local resolution; and

- Patients directly admitted to a MTC with a head injury (AIS 1+) and a GCS<13 (or intubated pre-hospital), and who do not require emergency surgery or interventional radiology within one hour of admission, receive a head CT scan within 60 minutes of arrival.

A patient cannot attract additional payments for both Level 1 and 2. For example a patient with an ISS score of 17 would get a maximum additional payment of the level 2 score, not both level 1 and level 2.

Health assessments for looked after children

In 2013/14, a currency was introduced for health assessments for looked after children placed out of area, with non-mandatory prices published. This was to incentivise assessments including all the necessary elements. A secondary issue was the difficulty in agreeing prices between providers and commissioners for out of area assessments. To reduce the problem of price negotiation we are proposing to mandate in 2014/15, for out of area health assessments, the prices that were published as part of the 2013/14 tariff package. The impact of doing this is likely to be very small with around 20,000 children placed out of area. Feedback has suggested that many organisations are already using the non-mandatory prices that were published for 2013/14.

Appendix D - Mapping of the National Tariff to the PbR Guidance 2013/14

					NTD						
	Page Count	Page number	N/A to NTD	Missing	Exec summary	Section1: Introduction	Section2: Context	Section3: Methodology	Section4: Regulated National Prices	Section5: Variations & Rules	Guidance
PbR Guidance 2013/14											
	231										
Section 1: Introduction	**9**	**11**									
Purpose		11			y	y					
Main changes in 2013-14		12			y	y	y	y	y	y	
Incentivising quality and better outcomes for patients		12			y		y				
Embedding efficiency and value for money within the tariff		13			y		y				
Promoting integration and patient responsiveness		13			y		y				
Expanding the scope of PbR		14	y								
Other changes		14			y						
Tariff information spreadsheet		15				y					
Scope of the national mandatory tariff		15			y	y					
Tariff adjustment		15			y			y			
Clinical negligence scheme for trusts		16			y			y			
Clinical audits		18									y
Help and advice		18			y	y					y
Section 2: Classification, currency and grouping	**5**	**20**									
Currency		20							y		y
Classification		20							y		y
Grouping		21							y		y
Data stages		22									y
PbR pre-processing stages		23									y
Grouping stage		24									y
PbR post grouping stage		24									y
PbR adjustment stage		24									y
Section 3: Admitted patient care	**15**	**25**									
Structure		25							y	y	
Elective care		25							y	y	
Marginal rate emergency tariff		26								y	
Short stay emergency adjustment		31							y		
Long stay payment		32							y		
Specialised services		33								y	
Zero price		35							y		
No tariff price		35							y		
Emergency readmissions		35								y	
Section 4: Post discharge tariffs	**5**	**40**									
Introduction		40							y		y
Implementation of post discharge tariffs		40							y		y

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Cardiac rehabilitation post discharge tariff		41							y		y
Pulmonary rehabilitation post discharge tariff		42							y		y
Hip replacement		42							y		y
Knee replacement		43							y		y
Recovery, Rehabilitation and Reablement (RRR)		44									y
Section 5: Outpatient care	**13**	45									
Structure		45							y		
Procedures in outpatients		46							y		
Outpatient attendances		47							y		
Introduction		47							y		
Consultant led and non-consultant led		48									y
First and follow-up attendances		48									y
Multi-professional and multi-disciplinary		49									y
Diagnostic imaging in outpatients		51							y		y
Pre-operative assessments		57									y
Zero price		57							y		
Section 6: Direct Access	**2**	58									
Introduction		58							y		
Direct access diagnostic imaging		58							y	y	
Direct access simple echocardiograms		58							y		
Airflow studies		58							y		
Flexible sigmoidoscopies		59							y		
Section 7: Urgent care	**1**	60									
Accident and emergency services		60							y		
Major trauma		60							y		
Section 8: Best practice tariffs	**65**	**61**									
Introduction		61							y		y
General guidance		61							y		y
Summary of BPT package		62							y		y
Pricing approach for appropriate setting BPTs		64							y		y
Acute stroke care		65							y		y
Adult renal dialysis		68							y		y
Cataracts		73							y		y
Day case procedures		76							y		y
Diabetic ketoacidosis and hypoglycaemia		79							y		y
Early inflammatory arthritis		81							y		y
Endoscopy procedures		85							y		y
Fragility hip fracture		87							y		y
Interventional radiology		90							y		y
Major trauma		92							y		y
Outpatient procedures		94							y		y

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Paediatric diabetes		97							y		y
Paediatric epilepsy		100							y		y
Parkinson's disease		102							y		y
Pleural effusion		104							y		y
Primary total hip and knee replacements		106							y		y
Same day emergency care		108							y		y
Transient ischaemic attack		112							y		y
Section 9: Exclusions	**12**	116									
Introduction		116								y	
Excluded services		117								y	
Cancer multi disciplinary teams		118								y	
Excluded procedures		118								y	
Soft tissue sarcoma surgery		118								y	
Pelvic reconstructions		119								y	
Head and neck reconstructive surgery		120								y	
Intracranial telemetry		121								y	
Balloon assisted enteroscopy		121								y	
Excluded HRGs		121								y	
Excluded TFCs		122								y	
Excluded drugs		122								y	
Excluded devices		125								y	
Section 10: Pathway payments	18	128									
Maternity pathway payment		128							y	y	y
Cystic fibrosis		139							y		y
Section 11: Chemotherapy and radiotherapy	9	146									
Chemotherapy		146							y		y
Radiotherapy		150							y		y
Section 12: Other currencies and non-mandatory prices	24	154									
Introduction		154							y	y	
Specialist rehabilitiation		155								y	
Health Assessments for Looked After Children (LAC)		160							y		
Ambulance services		161								y	
Critical care		165								y	
HIV adult outpatient services		167								y	
Renal Transplantation		169								y	
Acute phase of rehabilitation		173								y	
Adult hearing services		175								y	
Neurology and neurosurgery		175								y	
Non face-to-face outpatient attendances		176								y	
Direct access plain film x-rays		176								y	
Cochlear implants		176								y	

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Transcatheter Aortic Valve Implantation (TAVI)		176								y	
Genito-urinary medicine outpatient attendances		176								y	
Any Qualified Provider		177								y	
Assistive technology - telehealth and telecare		177								y	
Section 13: Flexibilities	10	178									
Introduction		178								y	y
Section 14: Other operational issues	7	188									
Market forces factor		188								y	
Monthly reporting		188								y	y
Non-contract activity		189								y	y
Devolved administrations		190								y	y
Never events		193								y	y
NHS number		193								y	y
Annexes	34	195									
Annex A Figure 1: Admitted patients		195									y
Annex A Figure 1a: Best practice tariffs		196									y
Annex A Figure 1b: Emergency readmissions rule		197								y	y
Annex A Figure 1c: Emergency readmissions rule and transfers		198								y	y
Annex A Figure 1d: Emergency readmissions and exclusions		199								y	y
Annex A Figure 1e: Short stay emergency adjustment		200							?		y
Annex A Figure 1f: Long stay payments		201							?		y
Annex A Figure 1g: Specialised services top-ups		202									y
Annex A Figure 1h: Home births		203									y
Annex A Figure 2: Outpatients		204									y
Annex A Figure 2a: Outpatient attendance HRG		205									y
Annex A Figure 3: A&E		206									y
Annex A Figure 4a: Cataracts best practice tariff		207							?		y
Annex A Figure 4b: Day case best practice tariffs		208							?		y
Annex A Figure 4c: Fragility hip fracture best practice tariff		209							?		y
Annex A Figure 4d: Stroke best practice tariff		210							?		y
Annex A Figure 4e: TIA best practice tariff		211							?		y
Annex A Figure 4f: Same day emergency care best practice tariffs		212							?		y
Annex A Figure 4g: Major trauma best practice tariff		213							?		y
Annex A Figure 4h: Interventional radiology best practice tariffs		214							?		y
Annex B: Coding guidance to generate BPTs for EVAR and UFE		215									y
Annex C: Evidence base for interventional radiology and primary total hip and knee replacements BPTs		218									y
Annex D: Flow of information to enable validation of major trauma best practice		221									y
Annex E: NHFD reports for the fragility hip fracture best practice tariff		222									y
Annex F: Emergency readmission review proforma		224									y
Annex G: Processing diagnostic imaging data		228									y
Annex H: Health Assessment for Looked after children checklist tool		230									y

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Code of Conduct for PbR 2013/14	**27**										
Introduction - the purpose of the Code of Conduct		4				y					
The scope and objectives of Payment by Results (PbR)		6				y					
Tariff setting		8				y					
General conduct of commissioners, providers and other organisations participating in Payment by Results (PbR)		9				y					
Commissioner responsibilities		11	y								
Provider responsibilities		13	y								
Information sharing		15	y								
Activity specification, care and resource utilisation and capacity		17	y								
Patient choice, referrals and treatment thresholds		19	y								
Innovation to improve access to, or quality of, services		20	y								
Billing and payment		22								y	
Enforcement		24	y								
Glossary of terms		25				y					
Useful links		27									y
2013-14 Tariff information spreadsheets	**152 (approx)**										
Adjustments since road test											
List of changes to spreadsheet since road test	1	2							y		
Mandatory Prices	**29**	3									
Admitted Patient Care & Outpatient Procedures	22	3							y		
Outpatient Attendances	1	20							y		
A&E	1	21							y		
Unbundled Services	1	22							y		
Maternity Pathway	1	23							y		
Other Mandatory Prices	1	24							y		
Non-mandatory Prices	**1**	25									
Non-mandatory Prices	1	25									y
Best Practice Tariffs	**20**	26									
Best Practice Tariffs	12	26							y		y
Best Practice Tariffs Flags - Overview	3	38									y
BPT - OPCS codes	1	41									y
BPT - ICD codes	2	43									y
BPT - HRG codes	2	44									y
Specialised Service Top-ups	**76**	46									
Specialised Services	1	46								y	
Eligible Providers	2	47								y	
SSC ICD & OPCS Codes	73	49									y
Exclusions and unbundled HRGs	**22**	123									

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Service, Procedure, Outpatient Treatment Function Code, Drug and Device Exclusions	5	123								y	
Processing and Zero Tariffs	1	128								y	
Removed Exclusions	1	129								y	
HRG Exclusions	4	130								y	
Mapping of High Costs Drugs	2	134								y	
Detailed High Cost Drug Exclusions	5	136								y	
Unbundled HRG List	4	141								y	
MFF index values	**7**	145									
MFF Payment values	4	145								y	
MFF - all versions	3	149								y	
Changes to Grouper	**1**	152									
Grouper Changes	1	152									y
Maternity pathway data definitions and requirements	**8**										
Antenatal pathway requirements and definitions	4	3							y		
Postnatal pathway requirments and definitions	4	7							y		
Payment by Results - Step by Step Guide	**41**					**REPLACED BY METHODOLOGY SECTION IN NTD**					
Reference 2013/14 document											
PbR and the Market Forces Factor	**28**										
The whole document will sit within the Guidance	28										y
Mental Health Payment by Results Guidance for 2013-14	**52**										
Introduction	1	4								y	
Moving forward in 2013-14	2	4								y	
Building blocks for mental health PbR	1	6								y	
Whats new for 2013-14	1	7								y	
Indicative cluster costs	2	8								y	y
Agreeing local cluster prices	2	10								y	
Quality and outcome measures	3	12								y	
Algorithm	1	15									y
Using the mental health currencies	1	16								y	
When should clustering take place	1	17								y	
Mental health assessments for clustering	3	18								y	
Cluster periods as contract currency	3	21								y	
Overall currency development	1	24									y

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Interaction between mental health clusters and IAPT	1	24									y
Personal health budgets - how will they interact with Mental Health PbR?	1	25									y
Exclusions	3	25								y	
Non contract activity	1	28								y	
Interaction between care clusters and acute HRGs	1	28									y
Data analysis and sources of information for commissioners and providers	2	29									y
Further information	1	31									y
Annex A - Organisational readiness self-assessment	3	32									y
Annex B - Developing a finance and activity schedule for 2013-14	8	35									y
Annex C - Sample Memorandum of Understanding	7	43									y
Annex D - Top 12 questions from the CQC survey	2	50									y
Mental Health Clustering Booklet	**62**										
Whole document will be annex to section 5	62									y	
Mental Health Clustering Tool - Initial Assessment Algorithm	**25**					**WHOLE DOCUMENT WILL SIT WITHIN THE GUIDANCE**					
The whole document will sit within the Guidance	25										y
Key Steps For Successful Implementation Of Mental Health PbR	**28**					**WHOLE DOCUMENT WILL SIT WITHIN THE GUIDANCE**					
The whole document will sit within the Guidance	28										y
David Flory Letter											
Replaced by Executive summary					y						