2021/22 National Tariff Payment System – a consultation notice

Impact assessment

March 2021 (Revised 1 April 2021)

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1. Introduction

1.1 Purpose of the document

1. This document presents our assessment of the likely impact of implementing NHS England and NHS Improvement's proposals for the 2021/22 National Tariff Payment System (NTPS). It should be read alongside the *2021/22 National Tariff Payment System – A consultation notice*[1] which provides full details of our proposals.

2. The aim of this impact assessment is to help providers and commissioners understand the likely financial impact of our policy proposals, under a certain number of significant simplifying assumptions. We have had to make these assumptions given the significant changes to contracting and payment arrangements for 2020/21, mainly driven by the COVID-19 emergency, and the proposed arrangements for 2021/22. This should support planning and help inform responses to the 2021/22 NTPS statutory consultation. To understand the impact of the proposals, in this document we compare whole year revenue impacts, even though the 2021/22 NTPS will not come into effect on 1 April 2021 or apply for a full year. The likely impact of the proposals would be limited by the amount of time the tariff is in effect.

3. The document sets out:

   - our estimated aggregate financial impact of the proposed 2021/22 NTPS national prices and unit prices and, where possible and appropriate, the likely impact of individual policy proposals, on provider revenue and commissioner expenditure, under a number of significant simplifying assumptions
   - an assessment of the impact of activity changes and the context of the actual 2020/21 contracting arrangements
   - the likely impact of the 2021/22 NTPS proposals on equality and patient choice
   - an assessment of the proposals against NHS Improvement's statutory duties.

[1] Available from: www.england.nhs.uk/publication/2021-22-tariff-consultation/

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

5. The tariff proposals which are the subject of this assessment are subject to consultation. The consultation period is 28 days ending on 30 April 2021 and is combined with the consultation on the national tariff. For further details on how to respond, please see the consultation notice.

1.2 Scope of the analysis

6. For the 2021/22 NTPS, we propose that the vast majority of secondary healthcare services would be paid for using an aligned payment and incentive approach, with a significant reduction in the number of national tariff prices. The only services that would continue to be paid for through national prices are unbundled diagnostic imaging. However, we would continue to calculate and publish unit prices for all services that had national prices in 2017/19 (ie before blended payment was introduced in 2019/20). These unit prices are available to use for activity outside the scope of the aligned payment and incentive approach, including activity commissioned under the NHS Increasing Capacity Framework, in accordance with the aligned payment and incentive rules.[2]

7. We propose to calculate national prices and unit prices using the same calculation method and currencies as the 2020/21 NTPS, rolling over 2020/21 price relativities with adjustments for the MFF, cost uplifts and efficiency factors.

8. Despite the move away from national prices, we considered that it would nevertheless be appropriate to assess the financial impact of the 2021/22 national and unit prices compared to the equivalent 2020/21 prices. This is because providers and commissioners may want to use the published prices when agreeing the fixed and variable payment elements. As the 2020/21 NTPS also rolled over price relativities, the 2019/20 NTPS prices are similar to both 2020/21 and proposed 2021/22 NTPS. We supplement this analysis by an assessment of the expected impact of activity changes and provide some high level financial information on the actual contracting arrangements for 2020/21 to

[2] Detailed information on the proposed aligned payment and incentive approach is provided in Section 6 of the consultation notice and Section 3 of the draft 2021/22 NTPS.

further review some of the simplifying assumptions underlying the comparison of the price changes.

9. For the purposes of this assessment, we have grouped the proposals for the 2021/22 NTPS into the following three areas:

   - **New policies –** the main policy changes we are proposing for the 2021/22 NTPS are the introduction of the aligned payment and incentive approach for almost all services.
   - **Rolling over 2020/21 price relativities –** we propose to use 2020/21[3] prices to set the price relativities for 2021/22. This is intended to provide financial stability for providers and commissioners and to enable them to focus on service transformation in line with the NHS Long Term Plan commitments.
   - **Adjustments to unit prices and updates to existing policies –** we propose to make limited changes in 2021/22. This includes adjustments for the market forces factor (MFF)[4] and updating national and unit prices to reflect changes in inflation, efficiency, CNST[5] contributions as well as some updates to best practice tariffs and local pricing rules.

10. It is important to make clear that the proposed tariff – and therefore this impact assessment – does not take into account costs relating to, or impact on activity from, COVID-19. This is because additional funding to support the NHS to respond to COVID-19 will be distributed outside of the tariff. We therefore make the simplifying assumption in our assessment that there will be no COVID-19-related impacts on costs, prices and activity. We think this is appropriate, because whilst COVID-19 is clearly going to have an impact, the actual impacts are very difficult to forecast, our assessment is mainly focussed on providing an assessment of the impact of the proposed tariff changes.

[3] The 2020/21 prices were a rollover of 2019/20 relativities which were based on 2016/17 reference costs data, the latest version of HRG4+ currency design and adjusted to 19/20 levels using the tariff cost uplifts and efficiency factors specified in the 2017/19 NTPS

[4] Market forces factor is a measure of unavoidable cost differences between healthcare providers, and a means of off- setting the financial implications of these cost differences.

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

1.3 Our assessment approach

Appraisals overview

11. The significant change to the scope of national prices that is proposed for the 2021/22 NTPS, and the uncertainty about activity and costs as a result of the COVID-19 pandemic, create an unusual context for this year's impact assessment. Recognising this, we have structured our assessment into four appraisals:

    - **Appraisal A**: quantitatively assesses the impact on provider income and commissioner expenditure, making the simplifying assumption that the scope of the tariff remained unchanged (ie we apply the simplifying assumption that the fixed element would be set by reference to the national prices and unit prices in the 2020/21 and 2021/22 tariff and that there will be no COVID-19 impact on activity, costs and prices). See Section 2 for details.
    - **Appraisal B**: provides a brief qualitative assessment of changes in activity levels, mainly focussing on the key drivers for activity change. See Section 3 for details.
    - **Appraisal C**: provides a high level overview of how total provider costs and income have changed between 2018/19 and 2020/21, which provides some illustrative information of how provider tariff income may be impacted in 2021/22, when making some simplifying assumptions. See Section 4 for details.
    - **Appraisal D**: provides an assessment of transferring CQUIN into the national tariff. See Section 5 for details.

12. In Appraisal A, we present the quantitative impact in tariff revenue and expenditure making the simplifying assumption that the fixed element of the aligned payment and incentive is calculated using the prices published as part of the 2021/22 NTPS. However, we note that the proposals for the fixed element do not specify that prices should be used in this way.

13. We nevertheless considered this appropriate because emergency payment block contracts for 2020/21 were based on the historic outturn values for 2019/20, which were formed from 2019/20 activity and prices and supplemented by additional funding streams such as the financial recovery fund. As such, our simplified assumption of maintaining the scope of the tariff (ie assuming that tariff prices – national prices and unit prices – are used for all income) can

usefully present the isolated impact of our policy proposals (when making the simplifying assumption that the supplementary funding streams remain in place).

14. In Appraisals B and C we consider the impact of activity changes following the COVID-19 pandemic, alongside information on total provider income and costs

15. These appraisals are intended to provide some useful background to help stakeholders assess the likely impact of our policy proposals in the round. However, they are not precise estimates of the actual impact of our policies.

Approach to the appraisals

16. To measure the effect of the proposed 2021/22 NTPS on provider revenue, Appraisal A compares provider tariff revenue using the proposed 2021/22 prices against the equivalent 2020/21 prices. To calculate tariff revenue we use a constant level of activity for both years (2018/19 activity as published in the Hospital Episode Statistics (HES)). Doing so allows us to present the isolated impact of proposed price changes (assuming 2018/19 activity levels and casemix – see Section 3 for discussion of changes in activity). We control for scale effects by expressing this difference in tariff revenue as a proportion of 2019/20 operating revenue.

17. Our assessment of the impact on commissioners presents the change in 2020/21 tariff expenditure to 2021/22 tariff expenditure as a proportion of 2020/21 allocations, under the same assumptions.

18. We assess the aggregate impact of the 2021/22 NTPS proposals on NHS providers by type (acute, specialist, teaching and non-acute providers), NHS England commissioners and CCG commissioners and we also conduct further analysis to isolate the effect of some of our key policies, like the MFF.

19. Appraisal B provides a qualitative assessment of the expected impact of activity changes, in particular considering the significant impact of COVID-19. Appraisal C provides some high level financial information, based on some significant simplifying assumptions.

20. We have also assessed the likely impact of the proposed 2021/22 NTPS on patients and given due regard to our public sector equality duty under the

Equality Act 2010,[6] to eliminate discrimination and advance equality of opportunity for groups with protected characteristics. This aspect of our analysis looks at how the financial impact of our proposals on providers and commissioners is likely to impact on the services provided/commissioned and how the proposed 2021/22 NTPS is likely to impact on access to services and the quality of care provided. We also consider our proposals' likely impact on patient choice. See Sections 6 and 7 for details.

1.4 Limitations and assumptions

21. The scope of our quantitative assessment is limited to income and expenditure of activity that has a national or unit price. We do not quantitatively assess other changes that may impact on provider revenue and commissioner expenditure, such as revenue streams from locally priced services that don't have unit prices and revenues from outside the national tariff like COVID-19 funding, financial recovery funding (or services that have non-mandatory or benchmark prices). This is because of data limitations and our assessment being focused on NTPS policy proposals.
22. We also do not quantitatively assess how the aligned payment and incentive fixed element is going to be set in practice, but we assess the likely impact of aligned payment using the simplifying assumption that prices are a reasonable way of estimating or indicating that likely impact, for the reasons given earlier in paragraph 13. We also show some very high level analysis of overall provider income and cost in 2018/19 to 2020/21 for context. We do not capture planned changes in service provisions in integrated care systems (ICSs).
23. Our quantitative assessment is based on the following assumptions:
    - **Duration of tariff** – we have assumed the tariff is in effect for a full year.
    - **Activity levels** – our base run uses 2018/19 activity levels and casemix. However, analysis of HES data over a 10-year time period suggests an annual compounded growth rate of around 2.5% across all types of acute hospital care. As a result, the actual impact of our proposals on tariff revenue and commissioner expenditure is likely to be different from the impacts presented in this document. Furthermore, we have not made any

[6] Under Section 149 of the Equality Act 2010 (Equality Act), NHS Improvement (Monitor) and NHS England have a duty, in exercising their pricing functions, to have due regard to the need to: eliminate discrimination, harassment, victimisation and any other conduct prohibited by or under the Equality Act, advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it and foster good relations between people who share a relevant protected characteristic and persons who do not share it.

adjustments for the significant impact that COVID-19 will have had on activity levels and mix. We set out a brief qualitative analysis in Section 3 and plan to produce quantitative analysis of the impact of a scenario based on applying activity growth assumptions in future tariffs.

- **Level of use** – our modelled scenario assumes that providers and commissioners use the NTPS prices for the fixed element, and that the fixed element covers 100% of activity. This assumption allows a comparison of our proposals on prices and the associated impacts on providers and commissioners. However, we note that the aligned payment and incentive rules do not anticipate this approach being used. This also assumes that COVID-19 had no impact on activity mix.

24. In Section 4, we make significant limiting assumptions for the financial income and costs of providers in the second half of the 2020/21.

1.5 Document structure

25. This rest of the document supports the statutory consultation notice on the proposed 2021/22 NTPS.[7] It is structured as follows:

    - **Section 2** presents the estimated aggregate financial impact of the 2021/22 NTPS proposals on provider revenue and commissioner expenditure.[8]
    - **Section 3** considers the impact of activity changes.
    - **Section 4** provides a brief analysis of NHS total provider income and costs between 2018/19 and 2020/21.
    - **Section 5** provides an assessment of transferring CQUIN into the national tariff.
    - **Section 6** considers the likely impact of our proposals in relation to the protected characteristics as described in the Equality Act 2010.
    - **Section 7** considers the likely impact of our proposals on patient choice.
    - **Section 8** contains the conclusions and next steps.
    - **Appendix 1** contains an explanation how the national tariff proposals would secure the discharge of NHS Improvement's general duties under sections 62 and 66 of the 2012 Act.

[7] Available from: www.england.nhs.uk/publication/2021-22-tariff-consultation/

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

2. Appraisal A - Anticipated aggregate impact of proposed policy changes

26. This section presents the overall impacts of the policy proposals under the simplifying assumptions set out in Section 1. In this scenario, our impact assessment considers the impacts on tariff revenue and expenditure, assuming the scope of the tariff remains unchanged from 2020/21 and the 2021/22 aligned payment and incentive fixed element is calculated as if using the national and unit prices. As set out in the previous section we consider this analysis to be appropriate for the purpose of impact assessing the tariff proposals as the block contracts for 2020/21 were set by reference to 2019/20 outturns, which would have been based on the 2019/20 national tariff and other revenue streams outside of the tariff at that time (eg the Financial Recovery Fund).

27. The impacts we are assessing have been modelled by combining policy proposals and aggregating their effect on national prices and unit prices. Our analysis assesses the impact of our 2021/22 NTPS proposals on NHS providers, independent providers, commissioners and sustainability transformation partnerships (STPs or ICSs where applicable).

28. We start this section by discussing the outputs of our base model run which simulates tariff revenues for providers and tariff expenditure for commissioners for 2020/21 and 2021/22, using 2018/19 HES activity data. We apply a constant level of activity to both years when simulating tariff revenue and commissioner expenditure to better understand the impact of proposed policy changes. We assess the impact of activity changes in Section 4.

29. More details on how we propose to calculate 2021/22 prices are available in Section 8 of Part A of the consultation notice.

2.1 Anticipated aggregate impact of all 2021/22 proposals on NHS providers, excluding non-acute

30. Figure 1 below shows the combined impact of our proposals for 2021/22 on tariff revenue for NHS providers (excluding non-acute) and reflects the effects of

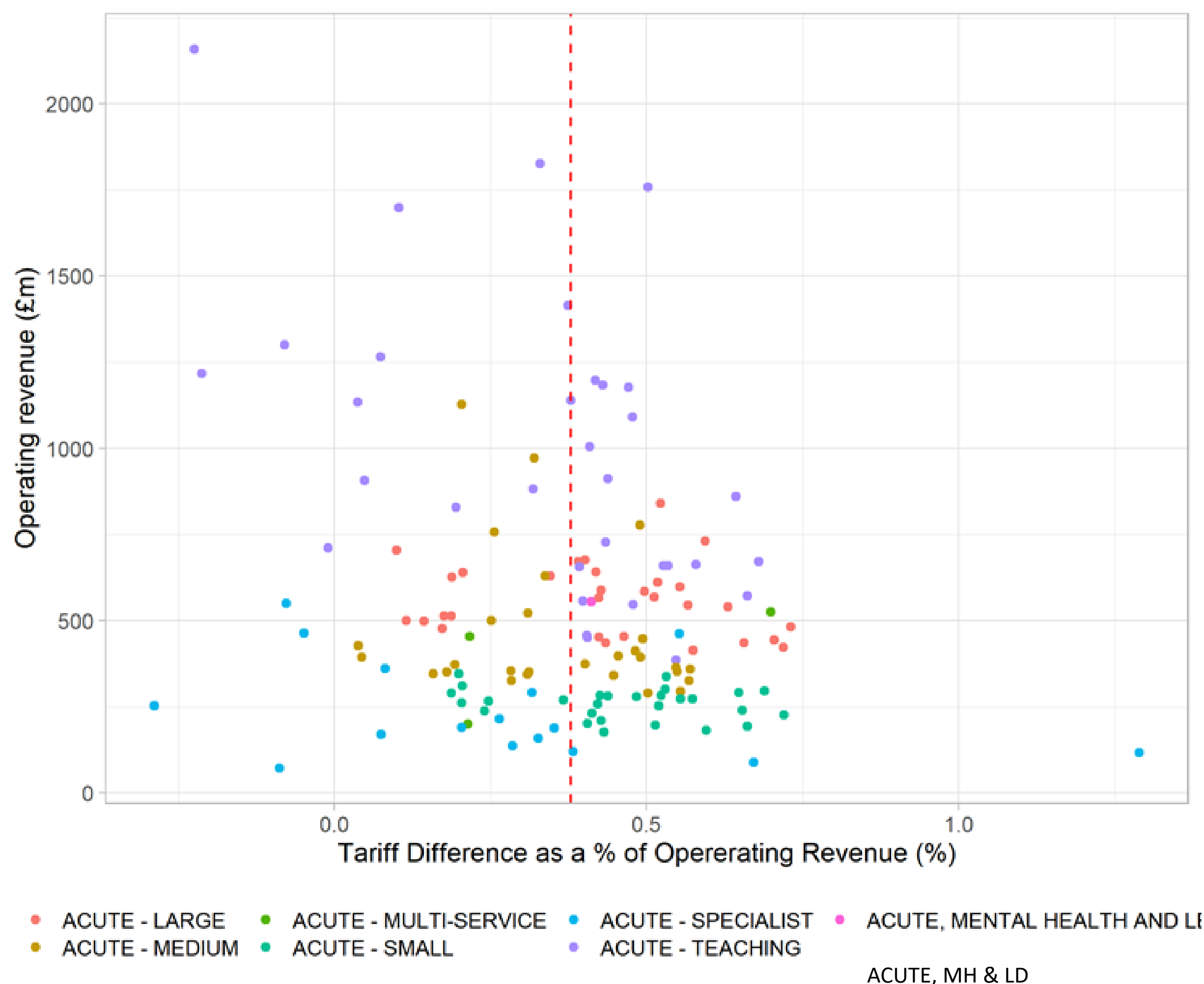
changes in prices under our scenario assumptions – ie it shows the difference between what a provider would receive in 2021/22 using the proposed 2021/22 prices when compared to 2020/21 prices, expressed as a proportion of 2019/20 operating revenue.

31. This scenario shows total tariff revenue increasing from around £40.5 billion to around £40.7 billion, which is an increase of +£0.27bn (+0.66%) in 2021/22 from 2020/21. The main driver of this change is the application of the uplift factor of around £75 million (+0.18%) for inflation and efficiency and around £187[9] million (+9.46%) to reflect the increase in CNST contributions by providers in 2021/22.

32. For acute providers, the change in tariff revenue in 2021/22 as a proportion of 2019/20 operating revenue is expected to range from -0.29% and +1.3%. The average change in tariff revenue, as shown in Figure 1, is around +0.38% as a proportion of 2019/20 operating revenue. This average excludes non-acute providers. If non-acute providers are included, the sector average change in tariff revenue as a proportion of 2019/20 operating revenue falls slightly to around +0.31%. This is because for non-acute providers, the proportion of total revenue that comes from national and unit prices is significantly less than that for acute, teaching and specialist providers.

[9] This is the amount allocated through the NTPS (£187m targeted to specific HRGs and around £15m allocated equally across the entire cost base via the cost uplift factor) to increase tariff in line with the overall increase in the CNST contributions collected by NHSR. In total, including the amount allocated outside the NTPS, CNST contributions are increasing by £210m or +9.47%.

Figure 1: Overall impact of 2021/22 NTPS proposals on tariff difference as a percentage of operating revenue for NHS providers, excluding non-acute



33. Our assessment suggests that, on average, NHS acute, specialist and teaching providers would see a change in tariff revenue as a proportion of 2019/20 operating revenue of around +0.38% (see Figure 2 below). For NHS acute, specialist, teaching and multi-service providers, 60% (81 out of 138) would see an increase in revenue greater than the average of 0.38% and for 94% of providers tariff revenue would increase.

34. For the remaining 6% of providers that we estimate their tariff revenue to decrease under this scenario the main driver for the change is the MFF transition to step three of the five-year glidepath. The outlier at around +1.3% in Figure 1 is a specialist Women's hospital, where their tariff revenue increases due to the increased prices within maternity services as a result of the proposed CNST contribution rates in 2021/22. Overall, maternity services in aggregate, taking into consideration adjustments for inflation, efficiency and CNST changes, is estimated to see an increase in tariff revenue of around £91 million. Therefore,

as a provider with a high proportion of their income derived from maternity services, the impact is greater as this provider would see a large proportion of the tariff increases in this area.

Figure 2: Number of NHS providers, excluding non-acute, that are above or below the average change in tariff revenue

Description	Acute - large	Acute - medium	Acute - small	Acute - specialist	Acute - teaching	Acute - multi-service	Total
Above average	21	13	21	4	20	1	80
Below average	9	15	7	12	13	2	58

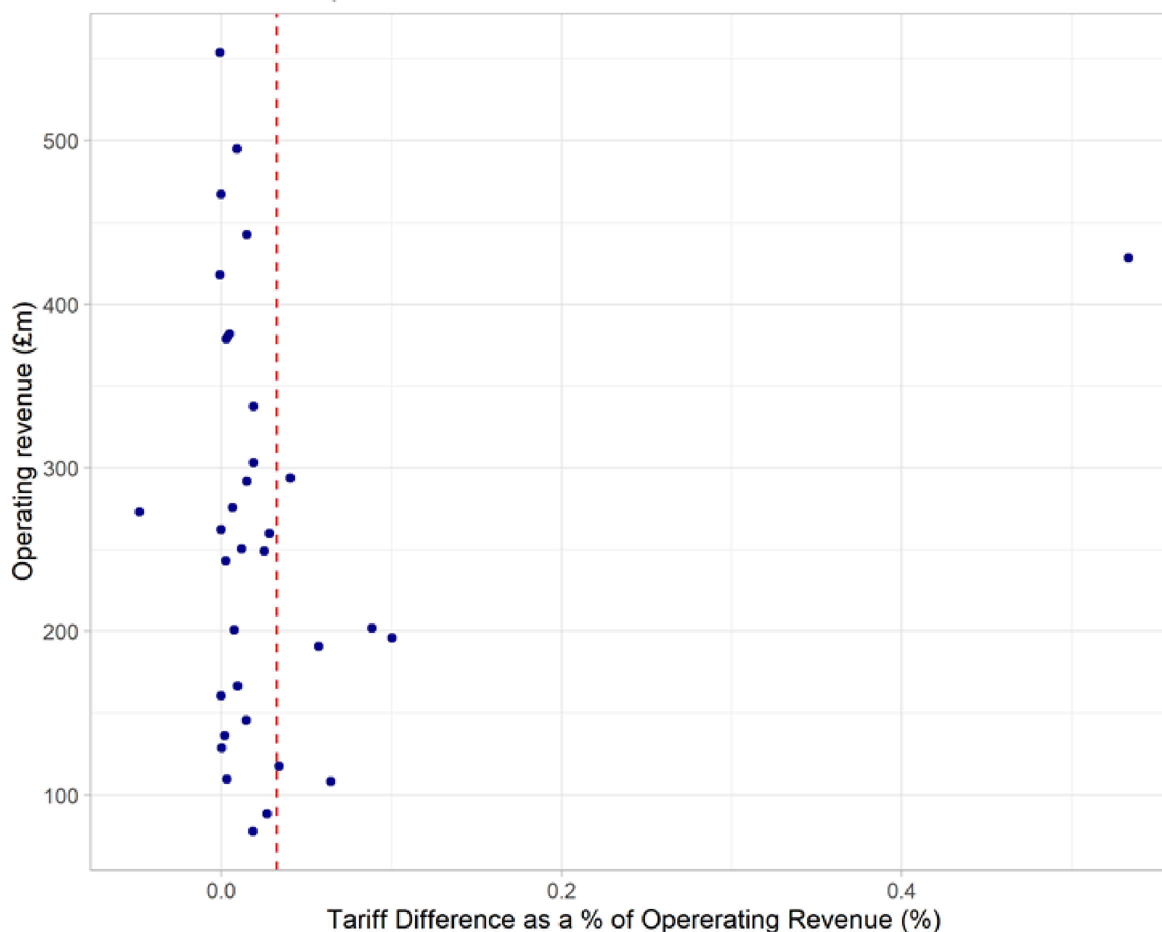
2.2 Anticipated aggregate impact of all 2021/22 proposals on non-acute NHS providers

35. Our analysis suggests that, for NHS non-acute providers, 2021/22 NTPS proposals are likely to have minimal impact on revenue. However, as a significant proportion of revenue for non-acute providers is not covered by national or unit prices, whilst the API proposals may also impact on such revenues, we are unable to quantify this in our assessment due to a lack of suitable data.

36. Our data shows that the 2021/22 NTPS proposals are likely to result in a small increase in revenue as a proportion of 2019/20 operating revenue for most non-acute NHS providers, with 30 out of 35 expected to see a positive impact in their revenue.

37. The outlier at around +0.5% is a recently merged provider that now offers services across hospital and community settings and as a result a higher proportion of their revenue is now affected from the changes in the proposed national and unit prices. The provider at -0.05% is a London community trust where their income is affected by the proposed MFF values.

Figure 3: Overall impact of 2021/22 NTPS proposals on tariff revenue for non-acute NHS providers



2.3 Anticipated aggregate impact of all 2021/22 proposals by type of providers

38. We expect that teaching and acute (small, medium and large) providers would benefit greatest from our proposals for 2021/22 as they represent the largest proportion of overall national and unit prices revenue and therefore receive a greater share of the overall increase in tariff revenue resulting from the adjustment for cost uplift and efficiency and tariff increases in line with higher CNST contributions in 2021/22. Figure 4 below sets out how we expect each type of provider to be impacted by the proposed changes for 2021/22.

39. For Independent providers we estimate the increase in tariff revenue to be around £7.7 million (+0.52% year-on-year). Roughly half of this change is likely due to the application of the CNST and the uplift factors net of efficiency,

respectively. Independent providers are not expected to generate significant tariff revenue for maternity services in 2021/22, therefore, they are not expected to receive a share of the significant increase in income from the increase to unit prices due to the expected higher CNST contribution rates for maternity in 2021/22.

Figure 4: Overall impact of 2021/22 NTPS proposals by type of provider

Type of provider	2020/21 total tariff revenue (£m)	2021/22 total tariff revenue (£m)	YoY change in tariff revenue (£m)	YoY % change in tariff revenue	Change in tariff revenue as % of 2019/20 operating revenue
Acute - large	9,275	9,345	70.6	0.76%	0.42%
Acute - medium	7,320	7,364	44.3	0.61%	0.34%
Acute - small	4,086	4,119	32.6	0.80%	0.45%
Acute - teaching	15,626	15,720	93.9	0.60%	0.29%
Acute - specialist	1,415	1,422	7.5	0.53%	0.20%
Acute - multi-service	816	824	7.4	0.90%	0.43%
Non - acute	473	477	3.5	0.73%	0.10%
Total NHS providers	39,012	39,271	259.8	0.67%	0.33%
Total Independent providers	1,469	1,477	7.7	0.52%	-

2.4 Anticipated aggregate impact of all 2021/22 proposals by point of delivery

40. Overall, across all types of providers, maternity and non-elective services are expected to see the greatest change in tariff revenue, driven by the higher increases for CNST in these services (approximately 1% for A&E and 4.4% for maternity). It is anticipated that for maternity services there would be an increase of around £90.9 million from 2020/21 levels (see Figure 5 below).

Figure 5: Overall impact of 2021/22 NTPS proposals by type of provider

Difference by Point of Delivery (£m)	Acute - large	Acute - medium	Acute - small	Acute - specialist	Acute - teaching	Acute - multi-service	Non - acute	Total
Accident and Emergency	9.2	6.1	4.3	0.4	10.7	0.6	0.4	31.7
Daycase	6.2	3.2	2.8	0.7	7.5	0.3	1.1	21.8
Elective	5.4	2.9	2.1	1.8	9.2	0.3	1.1	22.8
Non-Elective	20.7	11.5	9.5	1.6	27.8	1.6	1.4	74.1
Outpatient attendances	3	0.9	1.4	0.1	2.1	0.3	0.4	8.2
Outpatient procedures	1.9	1.1	0.9	0.1	2.2	0.2	0.2	6.6
Maternity	23.3	18.5	11.3	2.7	33.5	1.6	0	90.9

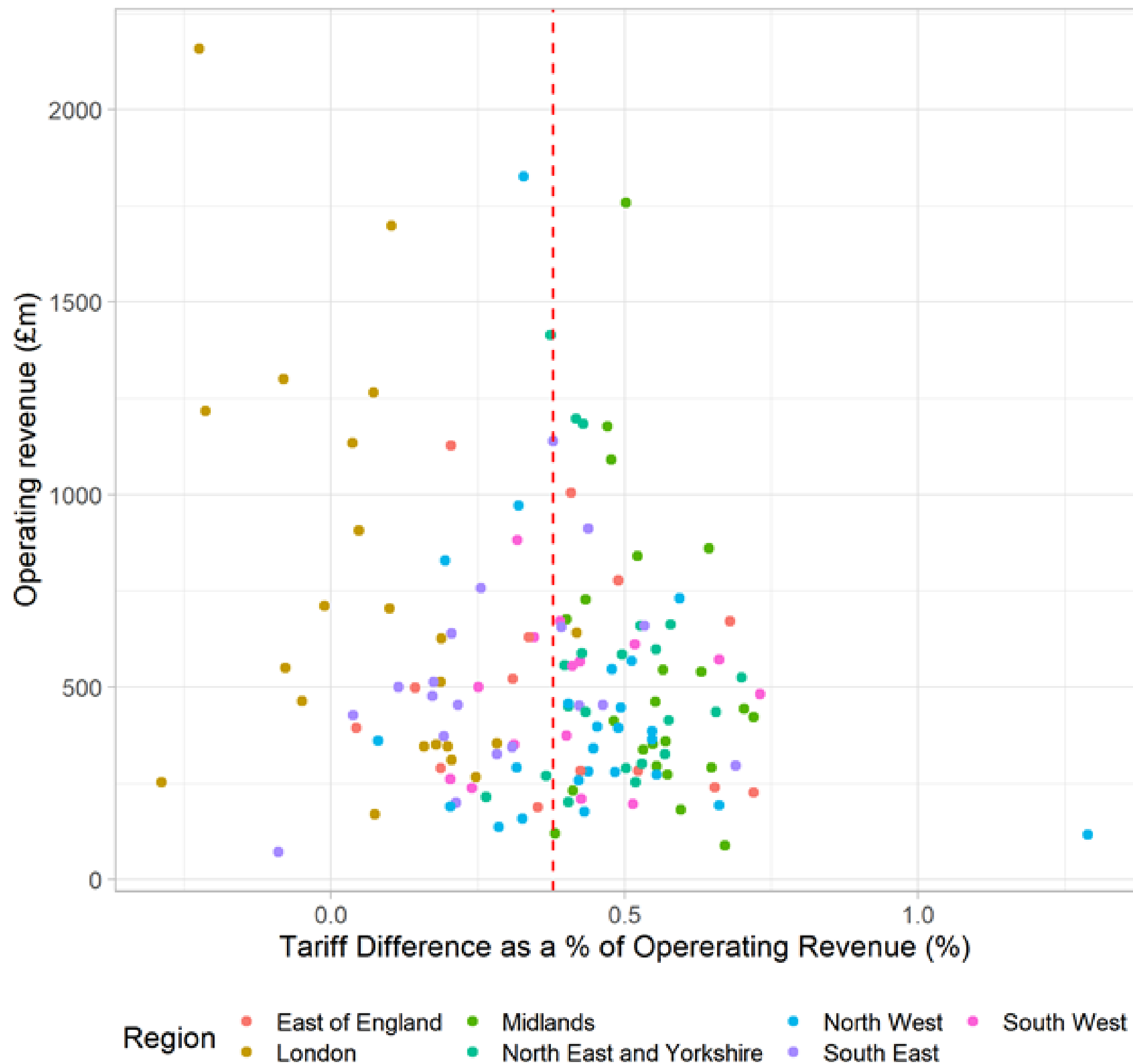
41. For 2021/22 we propose to keep on hold the transition path for prescribed specialised services (PSS) top ups. Hence, we do not anticipate a significant change in the tariff revenue providers receive from specialist top ups.

2.5 Anticipated aggregate impact of all 2021/22 proposals by region

42. Figure 6 below shows the aggregated impact of our proposals for 2021/22 on NHS providers by region. Based on our analysis, we expect the 2021/22 proposals to have the greatest positive impact on the Midlands, North East and Yorkshire and North West regions. On average these regions are likely to see tariff revenue increase by around +0.49% as a proportion of 2019/20 operating revenue. This is mainly driven by the changes to the MFF values.

43. Our analysis indicates that London providers are likely to see the lowest growth in tariff revenue as a percentage of 2019/20 operating revenue. The London region is expected to see an average change of around +0.07%. The main driver is the move to 2021/22 MFF values (which on average is reducing by more for London providers).

Figure 6: Overall impact of 2021/22 NTPS proposals on tariff revenue for NHS providers (excluding non-acute) by region



2.6 Anticipated aggregate impact of all 2021/22 proposals by STP/ICS

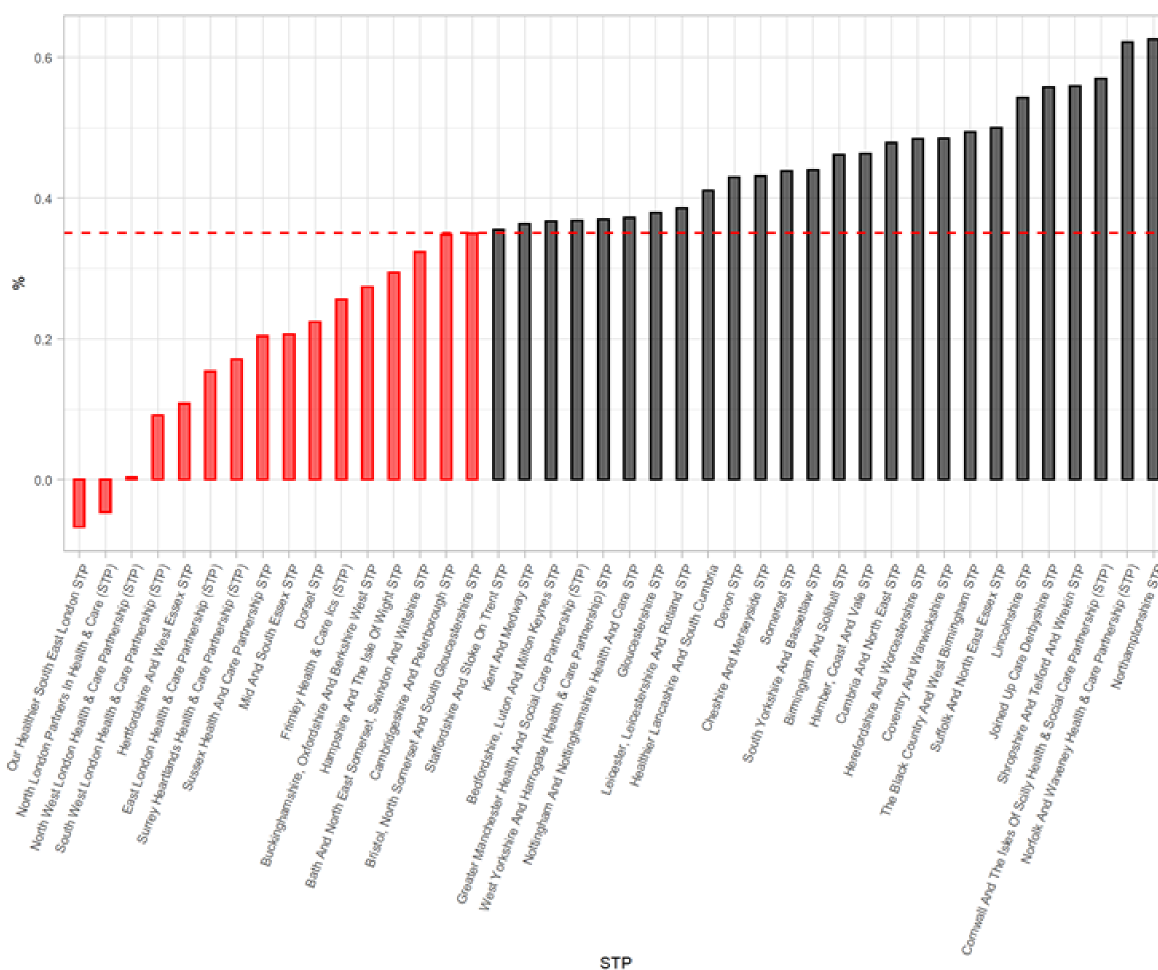
44. Here we present the impact of our proposals on systems (STPs or ICSs where applicable). We do this by aggregating provider 2019/20 operating revenue and proposed change in tariff revenue for 2021/22 for each STP/ICS and calculate the overall change as an absolute figure and as a percentage of aggregated 2019/20 operating revenue.

45. The results seen in Figure 7 below include non-acute providers to ensure we get the most accurate impact at STP/ICS level. Calculating at the STP/ICS level and including non-acute providers alongside acute and specialist providers in the

calculation results in a sector average change in tariff revenue as a proportion of 2019/20 operating revenue of +0.31% (compared to +0.38% when calculated at the provider level and excluding non-acute providers.)

46. Overall, 62% (26 of 42) of the STP/ICSs are anticipated to see above average (around +0.31%) change in tariff revenue as a percentage of aggregated 2019/20 operating revenue and two London STPs are expected to see their revenue to decrease slightly, driven by the changes to the MFF values.

Figure 7: Overall impact of 2021/22 NTPS proposals on tariff revenue for NHS providers (acute and non-acute) by STP/ICS



2.7 Anticipated impact of MFF

47. Applying the new MFF indices in 2021/22 (ie the third year of the five-year glide path) results in a reduction in the total amount paid through the MFF of approximately £141.5 million when compared to the MFF indices for 2020/21.

48. The aggregated effect on providers and commissioners is neutral, however, since the reduction in money distributed by the MFF is offset by an equivalent increase in national prices and unit prices.

49. Figure 8 below illustrates the effect of moving to the third year of the MFF glidepath on MFF payments by point of delivery (POD).

Figure 8: Change in MFF payments by POD

POD	MFF payment 2020/21 (£m)	MFF payment 2021/22 (£m)	Payment difference (£m)	Percentage difference (%)
AE	230.4	219.5	-10.8	-4.73
DC	362.7	345.1	-17.6	-4.87
EL	370.1	352.3	-17.8	-4.81
MAT	256.7	243.9	-12.8	-4.99
NEL	1,082.2	1,030.9	-51.2	-4.73
OPATT	381.3	362.5	-18.7	-4.92
OPPROC	137.0	130.0	-7.0	-5.16
Unbundled	107.9	102.6	-5.2	-4.9

2.8 Anticipated financial impact of 2021/22 NTPS proposals on commissioner spending

50. The estimated impact on commissioners' expenditure from the overall proposals is in Figure 9 below.

51. The size of the impact for commissioners may be marginally different to that for providers, as HES activity with no identifiable commissioner has been excluded for this analysis.

Figure 9: Overall impact of 2021/22 NTPS proposals on commissioner spending for local and central commissioners

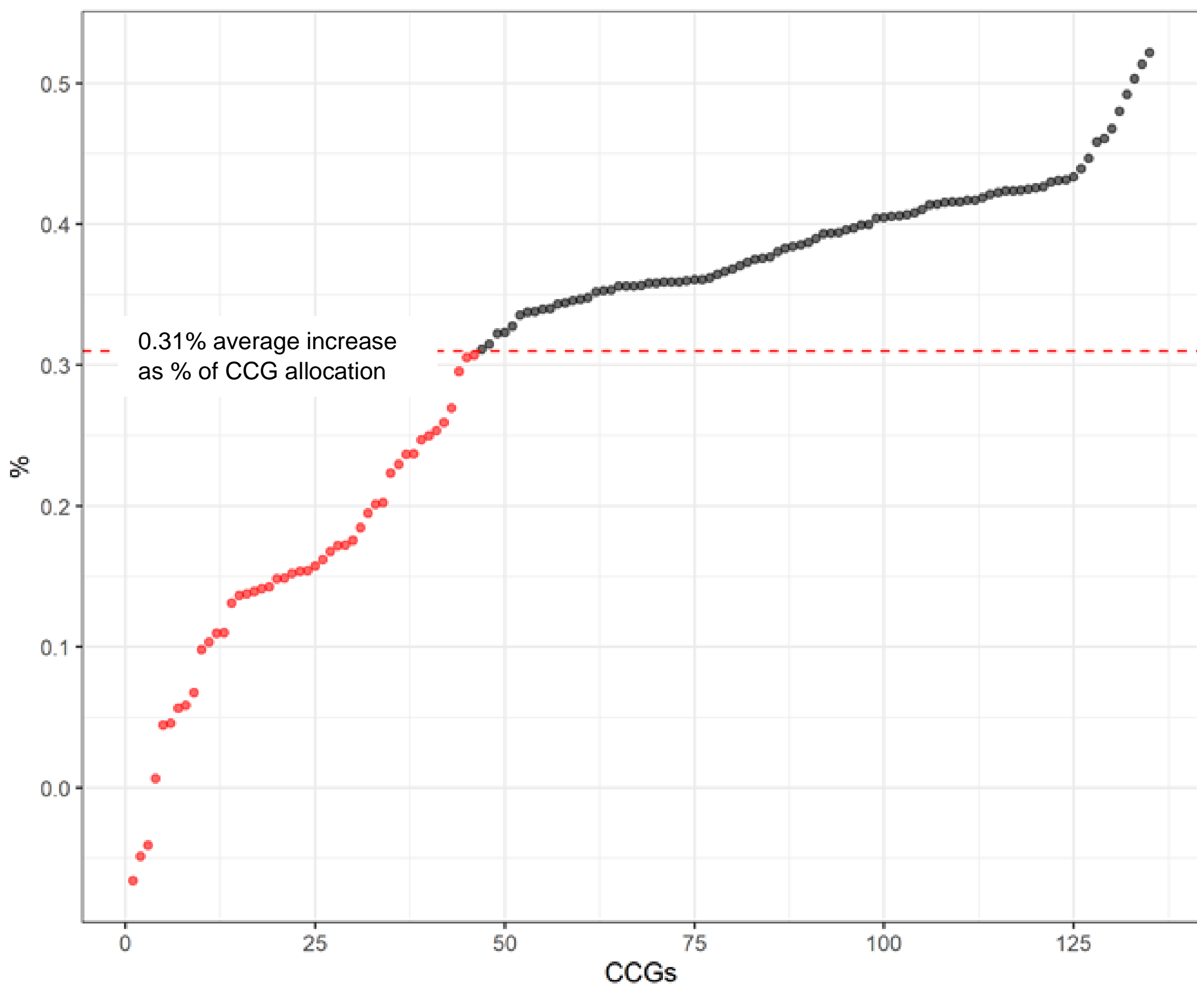
Commissioner type	Total tariff payment 2020/21 (£m)	Total tariff payment 2021/22 (£m)	Total difference (£m)	Percentage difference (%)
CCGs	33,802	34,047	245	0.72
NHS England Armed Forces and Prisoners	46	46	-	0
NHS England Specialised	3,361	3,375	14	0.42

52. The average increase for CCGs is 0.31% of 2020/21 allocations, Figure 10 shows the distribution across CCGs (based on 135 CCGs as at the start of 2020/21). For 98% of CCGs the tariff expenditure will increase whilst for almost

two thirds of CCGs (66%) their expenditure increase is above the average. The range is from -0.07% to +0.52% of allocations.

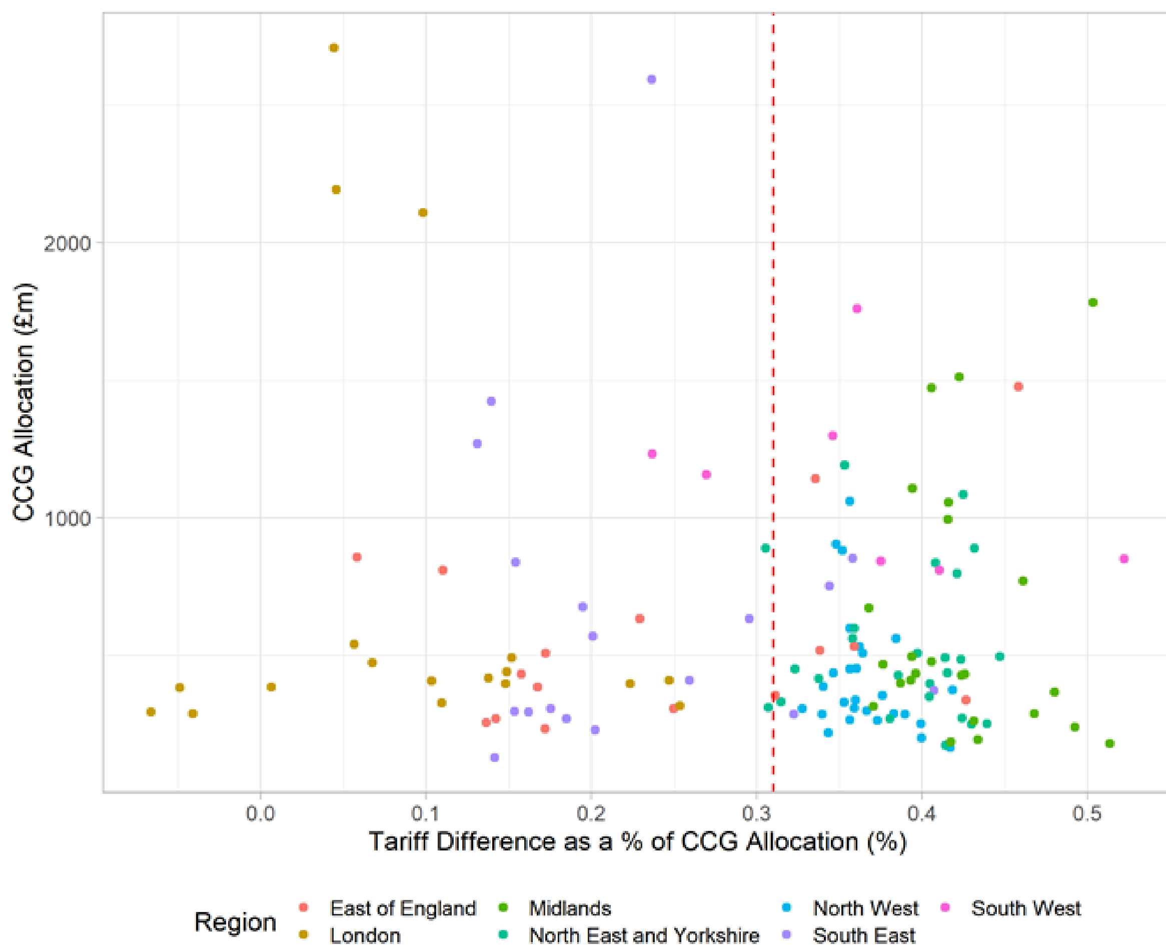
53. A very small number of CCGs show a reduction in expenditure due to the proposed changes in MFF.

Figure 10: Overall impact of 2021/22 NTPS proposals – change in tariff revenue as % of 2020/21 CCG allocations



54. The impact by region for CCGs as a percentage of 2020/21 allocations is in Figure 11 and by STP/ICS in Figure 12. The impact in tariff expenditure is mainly driven by the proposed changes to MFF, uplifts and CNST. As a result of the move to year three of the MFF glidepath, commissioners in London are likely to see a below average increase in their tariff expenditure whilst some may see a decrease. Commissioners in Midlands, North West and North East and Yorkshire would likely see an increase, as seen in Figure 11 below.

Figure 11: Overall impact of 2021/22 NTPS proposals for CCG tariff spending by region



55. The impact by STP/ICS for CCGs would differ for that for providers because of CCGs commissioning services from outside their STP/ICS and providers receiving income from outside their STP/ICSs, including that for specialised services.

Figure 12: Change in tariff revenue as a percentage of CCG allocation by STP

2.9 Anticipated impact of 2021/22 NTPS proposals by sub-chapter

56. This section shows the impact on provider revenue and commissioner spending of the proposed national and unit prices for different types of care. We use HRG subchapters to describe the price changes for different categories of care. HRGs are split into chapters, with each chapter relating to care for a particular set of conditions or treatments. These are further divided into subchapters that cover different categories of care. The only exceptions to this rule are the HRG subchapter WF (Non-Admitted Consultations) and subchapter NZ (Maternity). Subchapter WF covers payment for appointments for all types of care when a patient receives care or treatment without a national price and subchapter NZ covers payments for all the three phases of the maternity pathway: antenatal, delivery and postnatal care.

57. The proposed changes for 2021/22 are estimated to result in an increase in tariff revenue in all subchapters. A breakdown of the change by sub-chapter can be seen in Figure 13.

Figure 13: Anticipated impact of 2021/22 NTPS proposals by sub-chapter

58. The largest increase is seen at subchapter NZ - Obstetric medicine followed by VB – Emergency medicine, where their estimated payment increase is +2.9% and +1% respectively, as illustrated in Figure 14 below. This is a result of the proposed increase in CNST payments to cover the expected increase in costs for negligence claims.

Figure 14: The 10 HRG sub-chapters with the largest increase in tariff revenue

Sub-chapter	Sub-chapter description	Tariff difference (£m)	Percentage difference (%)
NZ	Obstetric Medicine	91	2.88
VB	Emergency Medicine	32	1.05
HE	Orthopaedic Disorders	2	0.91
PP	Paediatric Ophthalmic Disorders	0	0.91
PD	Paediatric Respiratory Disorders	2	0.83
PJ	Paediatric Dermatology Disorders	0	0.83
PW	Paediatric Infectious Diseases	2	0.83
PC	Paediatric Ear Nose and Throat Disorders	0	0.8
YH	Musculoskeletal Imaging Interventions	0	0.79
HC	Spinal Procedures and Disorders	5	0.76

3. Appraisal B - Impact of activity changes

59. We have set out previously that one of our limiting assumptions was that activity levels would remain constant at 2018/19 levels. Activity levels have, however, changed very significantly during 2020/21, mainly due to the impact of COVID-19 and would very likely continue to be impacted by it in 2021/22. Furthermore, the aligned payment and incentive proposals and other national policies, like the elective incentive scheme, are expected to further change activity within and across providers.

60. We have not been able to procure a meaningful quantitative forecast of activity levels for 2021/22 taking all the relevant factor into account. We note that:

    - Elective activity will likely be higher in 2021/22 compared to 2020/21 and likely also compared to 2019/20 given the significant backlog of activity – the exact extent of which will depend on the impact of COVID-19 on provider capacity (eg workforce, infection control, etc) and the effectiveness of other policies like the elective incentive scheme.
    - The aligned payment proposals mean that it is more difficult to assess the impact of non-elective activity growth on provider income as the arrangements for the variable rate on non-elective activity will differ depending on local agreements.

61. Overall, we expect the combination of the aligned payment and incentive proposals, together with other national policies, like the elective incentive schemes, to dampen the financial impacts of the differences between actual activity in 2021/22 and the activity levels assumed in this impact assessment.

4. Appraisal C Overview of costs and income

62. In this section, we provide an overview of how total provider costs and income have changed between 2018/19 and 2020/21. This may be helpful to providers and commissioners.

63. The two main elements of provider operating costs are pay costs and non-pay costs.

64. The main elements of total provider operating income are ‘income from patient care activities’ and ‘other operating income’.

65. Actual cost and income data were obtained for 2018/19 and 2019/20 from consolidated provider accounts. For 2020/21 the position was based on full year estimates provided at month 8.

4.1 Overview of NHS provider costs

66. Total provider costs between 2018/19 and 2020/21 are outlined in the table below. This shows that total provider cost changes are no too dissimilar to the prior year, which was less impacted by COVID-19.

£ Billions	2018/19	2019/20	2020/21 est
Pay costs	54.4	60.3	64.1
Non Pay costs	32.8	34.3	35.8
Operating Costs	87.3	94.5	100.4
Growth from prior year		*8.3%*	*6.2%*
Pay of total costs %	*62%*	*64%*	*64%*

4.2 Overview of NHS provider income

67. Total provider operating income is outlined in the table below. This includes all income, i.e. tariff related income as well as additional income streams from other

funding sources like the Financial Recovery Fund, COVID-19 funding, winter funding, etc.

£ Billions	2018/19	2019/20	2020/21 est
Operating Income	86.9	94.4	100.4
Growth from prior year		*8.7%*	*6.3%*

68. Operating income increased by 8.7% in 2019/20 compared to the prior year. The analysis indicates an increase of 6.3% in 2020/21 compared to 2019/20. The income increases are similar to the increases in costs.

5. Appraisal D - CQUIN

69. In Sections 6 and 8 of the consultation notice we set out our proposed approach for transferring CQUIN funding into the national tariff. This would involve aligned payment and incentive fixed elements being increased by 1.25% to reflect CQUIN funding. In addition, national and unit prices would be increased by a 1.25% adjustment in addition to the cost uplift factor.

70. The proposed aligned payment and incentive fixed element assumes 100% attainment of CQUIN metrics. Where attainment is below this level, proportionate payments would be deducted from providers via the variable element. All providers to which CQUIN applies will be expected to report CQUIN metric data.

71. Due to the nature of local agreement between commissioners and providers for CQUIN payments we do not hold a comprehensive dataset on CQUIN achievement rates or CQUIN payments by commissioners and receipts by providers. As a result, we cannot provide a quantitative impact assessment on provider and commissioners.

72. However, since the expectation is that CQUIN rules will broadly stay the same for most of the CQUIN payments, we do not expect a significant impact on providers, commissioners and patients from this change. This is because our proposals mainly change the funding route for CQUIN, rather than the CQUIN rules themselves.

73. As a result, we have provided the quantitative impacts in this document without the impact of transferring CQUIN funding into the tariff.

6. Impacts relating to equality

6.1 Overview

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

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

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

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

76. The nine characteristics that are protected under the Equality Act are: age, race (including ethnic or national origins, colour or nationality), sex, pregnancy and maternity, sexual orientation, marriage or civil partnership, gender reassignment, disability, and civil partnership and religion or belief (including lack of religion or belief). We also acknowledge the principle of parity of esteem, by which mental health must be given equal priority to physical health.

6.2 Methodology

77. For the purposes of this impact assessment, we have considered the impact of our proposals on the nine protected characteristics listed above. In particular, we have looked at the extent to which the 2021/22 NTPS proposals are likely to disadvantage individuals who share each of these characteristics. In this analysis, we apply the same assumptions set out in Section 1 of this impact assessment.

78. Patient age, race and sex are all recorded in 2018/19 HES. This enables us to quantify how the proposed changes to unit prices in 2021/22 would affect spending on patients by age, race and sex groups. We have therefore considered the potential impact of our proposals on these groups quantitatively as well as qualitatively. The other equalities characteristics are not recorded in HES, so for groups with these characteristics we have assessed the likely impact of our proposals qualitatively.

6.3 Assessment

Age

79. The age of a patient can have a major impact on hospital length of stay and associated healthcare costs. A number of healthcare currencies are split by age to reflect these differences in costs. Based on our assessment, we estimate the proposed NTPS prices would change spending for all age groups by between +0.28% to +1.38%.

80. We therefore do not expect the 2021/22 NTPS proposal to have a material disproportionate impact on different age groups.

81. Figure 17 below shows the anticipated change in spending for the different age groups, where the age field was populated in HES.

Figure 17: Anticipated changes in tariff payment by age group

Age group	Total payment 2020/21 (£m)	Total payment 2021/22 (£m)	Tariff difference (£m)	Percentage difference (%)
0-18	3,941	3,964	22.7	0.58%
19-65	17,096	17,251	155.5	0.91%
Over 65	16,408	16,488	80.7	0.49%

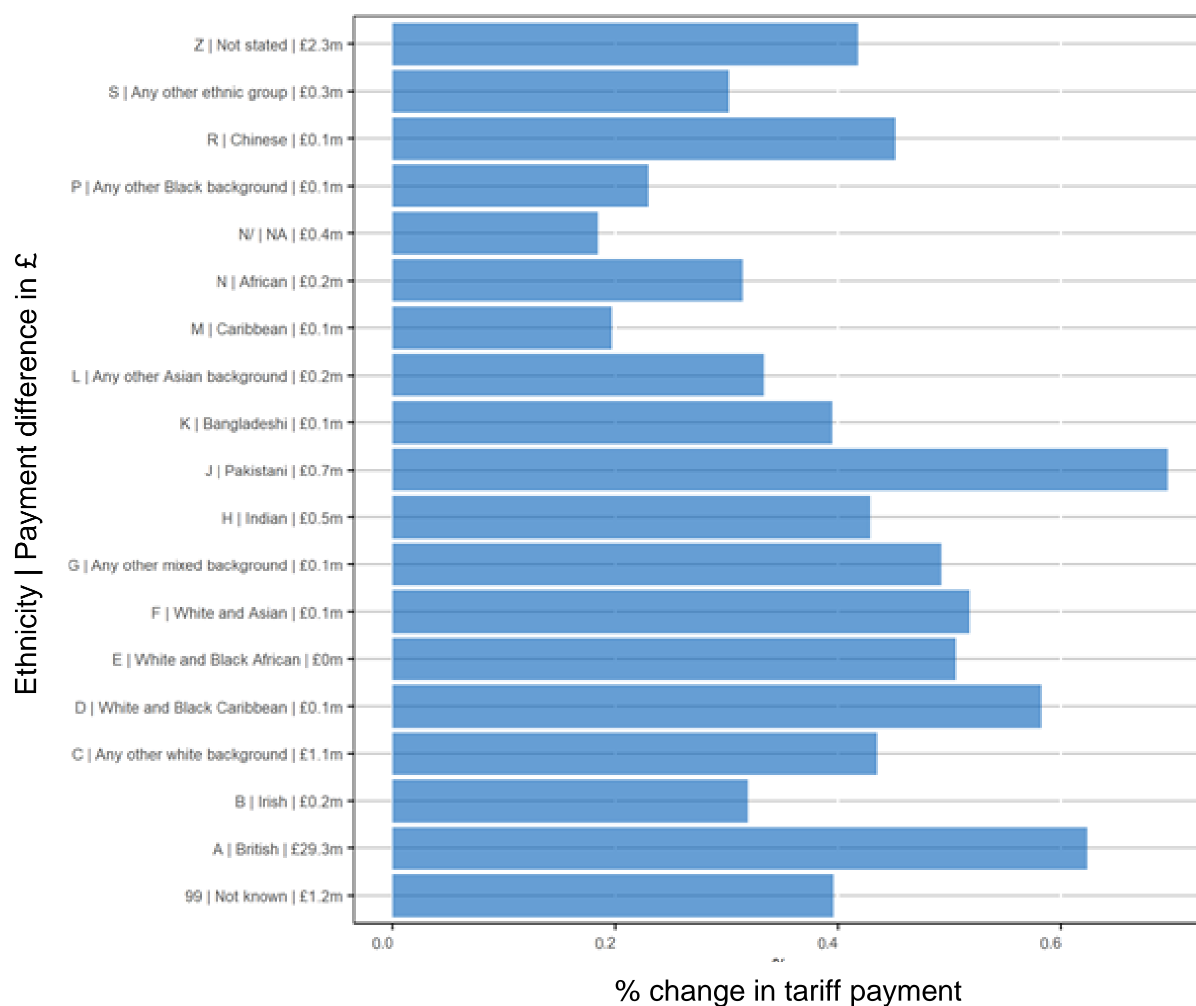
Race (including ethnic or national origin, colour or nationality)

82. The NTPS does not distinguish between patients based on their race, ethnicity or nationality. However, there are health conditions that are disproportionately experienced by people from certain ethnic groups and so the NTPS could have a disproportionate impact on different ethnic groups.

83. Based on our assessment, we estimate that the proposed NTPS prices would increase spending by between +0.2% and +0.7% for all ethnic groups, as seen in Figure 18 below. This increase is distributed across all ethnic groups and is driven by the proposed changes to inflation, efficiency and CNST.

84. We therefore do not expect the 2021/22 NTPS proposal to have a material disproportionate impact on patients based on race, ethnicity or nationality.

Figure 18: Anticipated changes in tariff payment by ethnicity



Sex

85. Certain procedures are, by their nature, specific to male and female patients and there are HRG chapters with sex-specific procedures, ie male or female procedures. Based on our assessment, using data where gender information was available, we estimate that the proposed unit prices would increase spending only slightly more for female patients, which is largely driven by the CNST adjustment for maternity services. We therefore do not expect the 2021/22 NTPS proposal to have a material disproportionate impact on men or women. Figure 19 illustrates this.

Figure 19: Anticipated changes in tariff payment from by sex

Gender Description	Total payment 2020/21 (£m)	Total payment 2021/22 (£m)	Tariff difference (£m)	Percentage difference (%)
Female	21,554	21,734	179.73	0.83%
Male	17,417	17,502	85.01	0.49%

Pregnancy and maternity

86. The 2021/22 NTPS proposals would increase spending on maternity by +2.9% (£91 million) and the biggest driver for this change is the tariff increases to reflect the expected increase to CNST contributions by providers in 2021/22 to cover expected cost of total claims. We are not aware of any other information what would suggest that the 2021/22 NTPS proposals have disproportionate impacts for this group of patients.

Sexual orientation

87. The national tariff does not distinguish between patients on the basis on their sexual orientation. We also do not hold statistics on the sexual orientation of patients. We are not aware of any other information what would suggest that the 2021/22 NTPS proposals have disproportionate impacts for this group of patients.

Marriage and civil partnership

88. The national tariff does not distinguish between patients based on their marital or civil partnership status, but we do not currently have datasets that would allow us to quantify the impact. We are not aware of any other information what would

suggest that the 2021/22 NTPS proposals have disproportionate impacts on population groups with a marriage or civil partnership status.

Gender reassignment

89. Gender reassignment is a specialised service provided by the NHS. The national tariff does not distinguish between patients based on gender reassignment. We do not currently have datasets that would allow us to quantify the impact. We are not aware of any other information what would suggest that the 2021/22 NTPS proposals have disproportionate impacts on this group of patients.

Disability

90. The HRG4+ phase 3 currency design enables us to distinguish between care provided for patients with different levels of complexity in order to reflect the expected higher use of resources to treat patients who do have complications and comorbidities. Comorbidities can be associated with disability. Therefore, the HRG4+ phase 3 design helps to ensure providers are more appropriately reimbursed for providing care to patients with disabilities. We do not currently have datasets that would allow us to quantify the impact, however. We are not aware of any other information what would suggest that the 2021/22 NTPS proposals have disproportionate impacts on this group of patients.

Religion or belief (including lack of belief)

91. The national tariff does not distinguish between patients based on their religion or belief. We do not currently have datasets that would allow us to quantify the impact, however. We are not aware of any other information what would suggest that the 2021/22 NTPS proposals have disproportionate impacts on this group of patients.

Other considerations

92. While some of the 2021/22 NTPS proposals might potentially have a negative impact on certain patients with protected characteristics, the rules on locally determined prices give commissioners and providers the flexibility to agree local payment approaches or prices to mitigate any unintended consequences of our proposals. We also expect providers and commissioners to take the necessary steps to ensure they comply with the equality duty when designing and/or commissioning services. Further to this, consultees are invited to provide any

comments or information which may assist with any further qualitative or quantitative assessment of impacts in relation to equality.

93. We have also considered the impact of our proposals on health inequalities. We do not currently have datasets that would allow us to quantify the impact. However, we are planning to review the availability of datasets to allow us to include more detailed analysis in future tariffs.

94. We have qualitatively reviewed our proposals' impact on health inequalities and have not identified any significant unmitigated concerns. Further to this, consultees are invited to provide any comments or information which may assist with any further qualitative or quantitative assessment of impacts in relation to health inequalities.

7. Patient choice

95. In this section, we present our assessment of the 2021/22 NTPS proposals on patient choice.

7.1 Overview

96. The NHS Long Term Plan (LTP) commits to reforming the payment system and moving away from activity-based payments to ensure a majority of funding is population-based. This is intended to support the development of integrated care systems (ICSs) and, by moving payment away from activity- and setting- specific payments, allow local areas to develop new models of care that reflect patient needs and choices. The LTP also sets out the goal of moving to a blended payment model for all services.

97. Our 2021/22 NTPS proposals aim to support the vision set out in the LTP and, in particular, to allow providers and commissioners to adopt more effective approaches to capacity and resource planning and focus on service transformation so they can deliver care to improve outcomes for the population they serve. This impact assessment should therefore be considered in the context of the move to increasing collaboration within and between systems.

98. The national prices and unit prices set as part of the tariff aim to support the API proposals by providing providers and commissioners with an indication of reasonable efficient costs of an average provider. All other things being equal, we would expect this to increase incentives for systems to improve the efficiency of services and therefore increase the capacity to deliver services within a given budget, which should indirectly support the effective operation of patient choice for elective care and other relevant services.

99. In addition, our payment proposals make no distinction on which provider should be commissioned to undertake patient care. In fact, through the thresholds, it recognises that different payment models are most appropriate for different values of contract and the providers who will hold these. The variable element also allows systems to adjust for provider utilisation (choice) against assumptions in the system plan.

100. None of the proposals are designed to reduce patient choice and we are not aware of any other information what would suggest that the 2021/22 NTPS proposals have disproportionate impacts on patient choice. Further to this,

consultees are invited to provide any comments or information which may assist with any further qualitative or quantitative assessment of impacts in relation to patient choice.

7.2 Assessment

Rollover of 2020/21 price relativities

101. The impact of rolling over 2020/21 price relativities, adjusted for inflation, efficiency and CNST, would vary depending on whether the final prices are higher or lower than provider's costs. However, the overall price level adjustments are applied evenly across all providers and, in the light of other aspects of the healthcare sector (eg other aspects of the regulatory regime), we expect the impact on rolling over national prices on patient choice would be limited.

Updates to MFF values

102. The proposed change to move to the third year of the published five-year MFF glidepath reflects the underlying costs of providing services by different providers more accurately. This should mean that providers with (structurally) higher costs get paid more for providing their services and helps ensure service provision remains financially viable. Ensuring providers are adequately reimbursed and therefore more viable will result in a situation where there is likely to be less of an impact on the choice for patients.

103. We therefore believe that the proposed move to the third year of the published five-year glidepath for MFF is unlikely to have a material impact on patient choice.

Aligned payment and incentive agreements

104. The aligned payment and incentive approach is intended to provide support to service transformation, including the adoption of innovative ways of working and increased collaboration between providers and commissioners within systems.

105. However, as collaboration between providers increases, there is a possibility that patient choice will be reduced, although this is not the express intention of the aligned payment and incentive proposals. Furthermore, this needs to be balanced against the intended benefits such as better integration and co-

operation and the intention to provide more patient-centred care pathways, which should increase the overall quality of services and patient experience. We therefore do not expect the proposed aligned payment and incentive approach to have an undue negative impact on patient choice.

Best practice tariffs

106. Best practice tariffs (BPTs) are intended to incentivise healthcare providers to deliver best practice which should result in improved quality of care and outcomes for patients and also increase patient choice. However, there may be providers that may choose not to adopt the service specification required to be eligible for the BPT or for reasons outside their control, are less able to achieve the criteria for a BPT.

107. The aligned payment and incentive proposals allow for local agreements that are best suited to the local population and should therefore be more flexible than the previous tariff arrangements. We therefore do not expect the BPT proposals for the 2021/22 NTPS to have an adverse impact on patient choice.

8. Conclusion and next steps

108. Our analysis in appraisal A shows that the proposed changes, were activity levels constant with 2018/19 levels, would be likely increase total tariff payments modestly in 2021/22 (+0.66% year-on-year) from the level estimated for 2020/21.

109. The main drivers of change in tariff revenue from 2020/21 to 2021/22 for both NHS and Independent providers are the net adjustment to proposed prices for cost uplifts (net of efficiency), the move to year 3 of the MFF glidepath and the increase in the CNST contributions by providers.

110. We estimate that for NHS providers 2021/22 tariff revenue as a proportion of 2019/20 operating revenue would range from -0.29% to +1.3%. For CCGs, the change in tariff spend in 2021/22 as a proportion of 2020/21 allocations is estimated to range between -0.07% and +0.52%.

111. Over the course of the 2021/22 tariff, we are planning to monitor and review policies, to inform future pricing policy development.

Appendix 1: NHS Improvement's statutory duties

In this appendix, all references to NHS Improvement refer to Monitor unless otherwise stated.

Under section 69(5) of the 2012 Health and Social Care Act (2012 Act), NHS Improvement's impact assessment must explain how the national tariff proposals[10] would secure the discharge of its duties under sections 62 and 66 of the 2012 Act.

NHS Improvement's general statutory duties are set out in sections 62 and 66 of the 2012 Act; and further statutory duties related to pricing are set out in sections 116(13) and 119(1) to (4) of the 2012 Act. This appendix sets out NHS Improvement's statutory duties and seeks to explain:

- how the 2021/22 NTPS proposals would secure the discharge of these statutory duties and,
- where appropriate, how NHS Improvement has complied with its duties in developing the 2021/22 NTPS proposals.

Where appropriate, we cross-reference to the consultation notice or this impact assessment itself. The following subsections address each provision in turn.

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

1.1 Section 116(13) of the 2012 Act

1.1.1. Section 62(1): Protect and promote the interests of patients[11]

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

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

We explain how the our 2020/21 NTPS proposals would secure the discharge of NHS improvement's statutory duties relating to pricing by reference to each limb of the duty in the section below.

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

NHS Improvement and NHS England's method for setting national prices and unit prices[12] follows two main principles;

- prices should reflect efficient costs,
- prices should provide appropriate signals to providers and commissioners.

Following these principles creates a strong incentive for providers to reduce their costs and, to promote efficient and effective service provision.

We consider that the 2021/22 NTPS proposals for national prices and unit prices have been developed in line with these principles and would promote economic, efficient and effective provision of healthcare services, balanced with the need to make healthcare services affordable for commissioners.

The aligned payment and incentive approach supports a more effective approach to capacity and resource planning and provides shared incentives for managing demand and better supports service transformation and integrated care. The fixed element of the payment approach would enhance the incentive for systems to redesign their care models to shift activity away from the hospital setting, which, over time should lead to reduced provider costs and more efficient delivery of outpatient services. This should ensure that patients can access new models of care, and that

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

[12] NHS Improvement and NHS England's method for setting national prices and unit prices is discussed in Section 7 of the consultation notice and Section 6 of the draft 2021/22 NTPS.

patients are seen in the most appropriate setting. It also means that providers can plan for and deliver more effective services to increase both their allocative and technical efficiency.

The method adopted for calculating adjustments to costs to better reflect the inflationary cost pressures facing providers reflects the expected increases in pay and non-pay costs and the central funding of procurement via Supply Chain Coordination Limited (SCCL). For SCCL, the intention of this policy is to increase efficiency across the system by encouraging joint procurement arrangements between NHS organisations. CNST uplifts in tariff are set with the intention that it incentivises trusts to reduce clinical negligence costs.

Setting an efficiency factor builds in an expectation that providers should be using innovation and improved working practices to increase their efficiency.

Additional costs relating to COVID-19 have been excluded from the NTPS as these are separately reimbursed.

Evidence from systems using similar payment approaches to the aligned payment and incentive method has demonstrated how it has helped to reduce waste. The variable element of this approach would help to mitigate the financial impact on both providers and commissioners where actual activity is different to activity levels assumed when setting the fixed payment. This would therefore help to promote that providers are appropriately reimbursed for services they provide.

The updates to the market forces factor (MFF) help ensure that provider revenue is appropriately adjusted for unavoidable cost differences between providers.

Best practice tariffs (BPTs) seek to incentivise higher quality care for patients by paying more to providers who meet best practice. Aligned payment and incentive agreements seek to better match the delivery of services to the cost of providing them, and commissioners and provider are able to include BPTs in the fixed and variable element.

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

To help maintain and improve the quality of healthcare services, our proposals seek to ensure that providers are appropriately reimbursed for the services they provide and, where possible, are provided with additional specific information to improve the quality of care (eg best practice tariffs).

The aligned payment and incentive fixed element is proposed to be set so that providers and commissioners discuss and agree services and activity levels they want to deliver, and how that would be reimbursed, at the start of the year. This would ensure providers are appropriately reimbursed for the services they provide, and support the delivery of the Long Term Plan objectives. Planning service delivery in this way and the certainty of funding should enable providers and commissioners to focus on ways to improve health outcomes by seeking to invest in preventative strategies, trying to keep patients healthier for longer and providing care in the most appropriate setting.

We recognise that by calculating national prices and unit prices based on average costs and affordability considerations for commissioners, the prices produced maybe too low for providers with costs above efficient costs. While we expect providers to reduce costs by improving efficiency, we also recognise that in some cases, the measures they could take to reduce costs could impact on the quality of care. However, this risk is significantly mitigated by the ways that the fixed element of the aligned payment and incentive approach is set, together with regulatory and reporting mechanisms designed to ensure care quality and appropriate patient access, such as Care Quality Commission inspections and the Single Oversight Framework.

Equally, we recognise that setting a fixed element could encourage providers to reduce access to care. However, this risk is likely to be at least somewhat mitigated by the variable element as well as other regulatory mechanisms designed to ensure access targets are met, including the contracting arrangements between providers and commissioners, the Single Oversight Framework and the publication of access statistics.

BPTs seek to increase the quality of care received by patients by redirecting funding from areas that are not achieving BPT standards towards those that are. There is a risk in the BPT proposals that local agreements of systems that do not choose to operate any BPTs, or anything in their place, quality of care could suffer. This is mitigated by:

- putting guidance in place
- monitoring the impact of our policy proposals
- work on a new quality payments scheme for future tariffs

The aim of the CNST uplift is not to compensate providers completely for any CNST costs they have incurred, but to pay an average price across all providers. This results in a situation where those providers which have large indemnities to NHS Resolution due to poor performance lose money, whereas those carrying out the service safely and to a high standard with fewer clinical negligence claims are financially rewarded – the intention of this policy is to incentivise providers to reduce the incidence of clinical negligence, which would improve patient safety.

Outside of the aligned payment and incentive approach and under the local pricing rules, providers and commissioners also have an option to vary away from the national tariff and agree local payment arrangements provided they can demonstrate that this is in the best interest on patients.

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

While calculating national prices and unit prices based on average costs is intended to incentivise efficiency, we recognise the risk to patient care and to the sustainability of healthcare service provision if prices are set too low. This is because providers that are under-reimbursed for delivering services could withdraw provision of services, or under-invest in the delivery of services they consider not to be financially viable.

NHS Improvement has had regard to the future demand for healthcare services in the development of the consultation notice proposals. For example, through the use of the HRG4+ phase 3 currency design for setting national prices and unit prices and the proposed updates to MFF, we have sought to ensure relative price levels are reflective of efficient relative cost

Furthermore, our aligned payment and incentive proposals are intended to encourage providers and commissioners to work more collaboratively and agree ways to use the available resources to manage healthcare demand and provide high-quality, responsive services for patients in the most efficient way. The aligned payment and incentive approach is expected to strengthen the incentive to invest in preventative strategies, to try to keep people healthier for longer, managing their long-term conditions more effectively and accessing services in a more sustainable way, including using remote consultations.

The aligned payment and incentive variable element aims to reduce the risk to providers and commissioners arising from unexpected changes in healthcare demand.

1.1.5. Section 62(3): Competition

NHS Improvement has had regard to competition in the development of our proposals. The proposed changes to the national tariff payment system that we consider may have implications for competition include:

- Rollover of 2020/21 price relativities
- Market forces factor
- The aligned payment and incentive approach

We have looked at whether the 2021/22 proposals are likely to change the number or range of suppliers on the market or encourage anti-competitive behaviour that could adversely impact patient care.

Rollover of 2020/21 price relativities

In setting the proposed 2021/22 prices we have largely kept price relativities constant. We also make adjustments that affect the level of all prices (ie inflation, CNST, and efficiency).

We do not expect any material impact on competition as the national prices and unit prices would apply to all providers (subject to the aligned payment and incentive rules) and are largely unchanged from the previous tariff.

We therefore do not expect the proposal to rollover 2020/21 price relativities to adversely affect the number or range of providers or encourage anti-competitive behaviour which may have a negative impact on patient care.

Market forces factor

The proposed change to move to the third year of the published five-year MFF transition path is intended to better reflect differences in non-controllable cost differences between different providers. We therefore expect the proposal to move to the third step of the five-step transition path for the MFF to have a beneficial effect on the number or range of providers and that they would not encourage anti-competitive behaviour which may have a negative impact on patient care.

The aligned payment and incentive approach

The aligned payment and incentive approach is intended to provide support to service transformation, including the adoption of innovative ways of working and the delivery of outpatient care in different settings. This in itself is not expected to materially impact on the number of providers and choices for patients.

However, as the aligned payment and incentive proposals are intended to increase collaboration between providers, there is a possibility that competition between providers reduces. However, this is an intended consequence and it is expected that the benefits of collaboration would outweigh any reduction in competition between providers, which would be beneficial to patients who are expected to be able to receive a more integrated care offering.

In addition, activity commissioned under the NHS Increasing Capacity Framework would be outside the scope of aligned payment and incentive agreements.

We therefore do not expect the proposed aligned payment approach to adversely affect the number of providers or encourage anti-competitive behaviour which may have a negative impact on patient care.

Best practice tariffs

In general, we expect BPTs to incentivise healthcare providers to deliver higher-quality services which lead to better patient outcomes and therefore have a positive impact on competition. However, there may be providers that, for reasons outside their control, are less able to achieve the criteria for a BPT. These providers may choose not to adopt the service specification required to receive the BPT price. Providers would still be paid for the care, albeit at a lower price, or within the fixed element of their payment

We therefore do not expect the proposals for BPTs to adversely affect the number or range of providers or encourage anti-competitive behaviour which may have a negative impact on patient care.

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

The proposed aligned payment and incentive approach is designed to incentivise commissioners and providers to work more collaboratively and agree ways to use the available resources to manage healthcare demand. It is a key part of funding the delivery of more integrated services and supporting new clinical models being rolled out across different integrated care systems. A further objective is to provide a framework of payment to support the development and implementation of a system plan rather than a 'one size fit all' payment approach, enabling systems to

redistribute funding resources to front line services to deliver quality and health outcome improvements to the population they serve.

The local variation rules are intended to give commissioners and providers an opportunity to innovate in the design and provision of services for patients. This might include, for example, designing care models that integrate elements of primary care, secondary and social care.

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

We undertook a range of consultation and engagement activities as part of developing the 2021/22 NTPS proposals.

For example, all stakeholders, including patients and other members of the public had an opportunity to review and comment on our national tariff proposals by reading the published tariff engagement document for the 2021/22 national tariff.[13] In addition, we held public facing webinars on our proposals during October 2020, which were delivered virtually and free for anyone to attend.

Patient representative and other representative groups were also invited to comment as part of the stakeholder engagement process and their feedback was taken into account and used to inform NHS Improvement and NHS England's final proposals. We do, however, recognise that while members of the public are invited to comment on our proposals, the NHS payment system maybe too technical and may not be of great interest to patients and the wider public.

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

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

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

Due to COVID-19, there was less clinical availability to discuss proposals with during the early part of the development process in particular. For example, the Expert Working Groups (EWGs),[14] run by the National Casemix Office, did not meet until

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[13] https://improvement.nhs.uk/resources/developing-payment-system-2021-22/
[14] EWGs are responsible for advising on the design of the casemix classifications known as healthcare resource groups (HRGs) and consist of clinicians nominated by their professional bodies and Royal Colleges

later in the year and therefore we did not discuss the proposed price relativities with them. However, as the prices were being rolled over from 2020/21, they had previously been reviewed by EWGs on two occasions. However, we did engage with other clinical stakeholder and interested groups. We specifically engaged with clinicians on the potential impacts of the aligned payment and incentive proposals and the proposed changes to BPTs.

In addition, the engagement document presented an opportunity for the wider clinical community to review and comment on our proposals. We also involved the clinical community and other experts, eg. pharmacists in the process for reviewing and selecting drugs, devices and procedures for the high-cost exclusion list.

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

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

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

- cover a wide range of NHS services, providers and settings, including acute and community services, and both nationally and locally determined prices. The only exceptions are areas where the legislation specifically provides an exception (eg public health services) or an existing payment mechanism (eg primary care services).
- cover mental health services as well as physical health services.
- are specifically designed to support a comprehensive and efficient NHS which provides services centred around patient needs.

We have worked to ensure our tariff proposals align with NHS England's annual mandate. All the proposals in the consultation notice have been jointly decided by NHS Improvement and NHS England; the latter is subject to the duty in section 1(1) of the NHS Act 2006 concurrently with the Secretary of State.

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

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

NHS Improvement has had regard to its duty under Section 62(10) when setting prices. We set uniform national prices and unit prices across different settings which apply to both public and private providers, subject to the aligned payment and incentive rules. We expect the proposals to differentiate between providers on the basis of the services they provide and /or types of patients they treat, and not on the basis of their status. As such, the proposals are not designed to promote the provision of services by a particular type of organisation. Similarly, the proposal to continue using the HRG4+ phase 3 currency design and the proposed changes to MFF take into account differences between cost and patient mix of providers.

We therefore do not expect the proposals to lead to discrimination between providers.

1.2 Section 116(13) of the 2012 Act

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

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

We have applied the payment principle that prices should reflect the costs that a reasonably efficient provider should expect to incur in supplying healthcare services to the level of quality expected by commissioners. We have also had regard to the risks of prices being set too low, including the potential risks to safety.[15] The considerations set out in relation to Section 62(1)(b) of the 2012 Act (quality – see Section 1.1.3 of this Appendix) are also relevant.

In relation to locally determined prices, the requirement for commissioners and providers to apply the principle that local payment approaches must be in the best interests of patients is being retained. This requirement also forms part of the aligned payment and incentive rules. In applying this principle, we expect providers and commissioners to consider how a local payment approach would maintain or improve safety. In addition, adjustments to payments through the MFF and any local modifications can help to ensure that healthcare services can be delivered safely

[15] See Section 8.7 of Part A of the consultation notice.

where they are required by commissioners for patients, even if the reasonably efficient cost of providing these services is higher than the national price.

There are also significant other mechanisms in place to ensure the safety of patients, in particular health and safety legislation and the oversight by the CQC.

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

We have had regard to the risk to continuous improvement in quality when setting our proposals. Our proposals support continuous improvements in the quality of care and services. In particular, the aligned payment and incentive approach allows radical redesign of patient pathways and redistribution of hospital specialties, and ensures that elective recovery is not shaped by income generation but by local health and care strategic plans and by the need to address health inequalities.

BPTs are also designed to encourage best practice and to incentivise improvements in quality.

In relation to locally determined prices, we propose to retain the requirements for commissioners and providers to apply the principle that local payment approaches must be in the best interests of patients – in particular that they should consider how a local payment approach would maintain or improve quality (outcomes, patient experience and safety). This requirement also forms part of the aligned payment and incentive rules. The considerations set out in relation to Section 62(1)(b) of the 2012 Act (see Section 1.1.1 above) are also relevant.

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

We have had regard to the needs of commissioners to ensure fair access to services and best use of resources.

Section 1.1.2 of this appendix explains how the proposals contribute to economic, efficient and effective care; for example, through the use of the HRG4+ currency, refreshing the cost-uplift and efficiency factor estimates, AIP and proposals for the MFF. This in turn supports the best use of resources as commissioners can undertake an assessment of the relative value of healthcare options. This is supportive of the aim that patients have equal opportunities to access NHS care. They also help commissioners commission the most effective mix of services for their population within the available budget. For the example, the API proposals are

expected to make it easier for commissioners and providers to reshape their service offerings to the benefit of patients.

The MFF helps to ensure that provider revenue reflects the unavoidable financial pressures they face due to geographical cost differences and so prevents these from affecting patients' access to care. Our proposal to update the MFF values are expected to support patients' fair access to care.

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

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

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

Our aligned payment and incentive proposals are specifically designed to enhance co-operation between providers and to provide more patient-centred services. They are intended to facilitate local discussions about the needs of patients and how the payment system can support safe, effective and evidence- based care that is, at a minimum, NICE concordant. Delivering high quality care can reduce the need for future hospital visits and co-operation and integration of services can result in people better managing their own long-term conditions. The aligned payment and incentive approach is intended to strengthen the incentive to deliver such care.

Pricing rules for locally determined prices allow for local variations which, for example, promote service integration (eg pathway payments). Under rule 1, providers and commissioners must follow a set of principles when agreeing a local payment approach. These principles include the requirement for constructive engagement between providers and commissioners. This requirement also forms part of the aligned payment and incentive rules, which include a variable element to support elective activity and achievement of BPT and CQUIN criteria. Areas that do not want to apply a variable element would need to apply to NHS England and NHS Improvement for approval, with a justification of how the local system plan will deliver the aims of supporting elective recovery and improving quality.

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

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

However, the aligned payment approach allows providers much more flexibility in planning future service design, which could promote more research and training in this area.

Some BPTs are linked to data submission to clinical audits and so there is a risk that changes in the operation of BPTs may lessen the incentive to provide good quality timely information to audits which are used by the research community. We aim to mitigate this risk through guidance documents.

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

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

1.3 Section 116(13) of the 2012 Act

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

NHS Improvement has had regard to the mandate as the proposals were formulated; a number of our proposals support mandate objectives. For example, objective 2 of the mandate is "progress towards the effective implementation of the NHS Long Term Plan", which includes the reform of the payment system.

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

1.4 Section 119 of the 2012 Act

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

1.4.1. 119(1): Fair level of pay for providers of healthcare services and having regard to differences between providers

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

The HRG4+ phase 3 currency design is designed to better reflect the costs associated with the provision of care of varying levels of complexity and would therefore support fair reimbursement for providers that treat patients with variations in complexity. The specialised services top-up policy enables more cost-reflective payments for specialist care which are not accounted for under the HRG4+ currency. The policy has been explicitly developed to ensure provision of specialist and complex care to be more appropriately reimbursed.

In addition, the MFF deals with non-controllable cost differences between providers. This policy is designed to compensate providers for non-controllable cost differences such as staff costs and the cost of land and buildings. This helps to ensure that providers receive a more cost reflective level of reimbursement. The proposed move to the third year of the published MFF values would further contribute to this aim.

The aligned payment and incentive policy enables local systems to reflect different costs in service delivery relating to local context without the need for this to filter through into national prices.

In addition, activity commissioned under the NHS Increasing Capacity Framework would be outside the scope of aligned payment and incentive agreements.

The rules for locally determined prices has a requirement to act in the best interests of patients. Cost-effectiveness must be considered as part of this requirement.

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

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

A system of national currencies is one of the building blocks of the payment system for NHS care. For 2021/22, NHS England and NHS Improvement propose to continue using the HRG4+ phase 3 currency design for the national prices and unit prices. We feel that HRG4+ reflects the costs associated with the provision of care of varying levels of complexity.

The aligned payment and incentive approach would require a continued focus on data; particularly the need to continue to improve currencies and activity and cost information.

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Publishing Approval Reference: PAR0306