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2022/23 National Tariff Payment System – a consultation notice

Impact assessment

24 December 2021

Contents

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 2022/23 National Tariff Payment System (NTPS). It should be read alongside the *2022/23 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 systems understand the likely 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 driven by the response to the COVID-19 pandemic. This should support planning and help inform responses to the 2022/23 NTPS statutory consultation.

3. In line with the commitments in the NHS Long Term Plan a blended payment approach remains the direction of travel for the NHS payment system. The aligned payment and incentive approach is based on a type of blended payment, based on the model introduced in the 2019/20 tariff. This impact assessment will consider the likely impact of the aligned payment and incentive approach and will not cover alternatives to this blended payment approach.

4. The document sets out:

   - our estimated aggregate financial impact of the proposed 2022/23 NTPS national prices and unit prices on provider revenue and integrated care systems (ICS) expenditure (Section 2),
   - a qualitative assessment of the proposed Aligned payment and incentive (API) approach and the likely impact on patient choice (Section 3),
   - the likely impact of the 2022/23 NTPS proposals on equality (Section 4),

[1] Available from: www.england.nhs.uk/pay-syst/national-tariff/consultation-on-2022-23-national-tariff/

- an assessment of the proposals against NHS Improvement's statutory duties (Appendix 1).

5. 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.

6. While the National Tariff Payment System for 2022/23 will be based on legislation as set out in the Health and Social Care Act 2012, changes proposed by the Health and Care Bill may come into effect (if enacted) during the period that this tariff is in place. As a result, tariff payment proposals for 2023/24 may be based on amended and updated legislation.

7. The tariff proposals which are the subject of this assessment are subject to consultation. The statutory consultation period is 28 days, ending on 21 January 2022. However, given the launch of the consultation in December, and the bank holidays for Christmas and new year, we will continue to consider objections and feedback submitted until midnight at the end of **28 January 2022**. For further details on how to respond, please see the consultation notice.

8. The findings of the impact assessment are:

   - An increase in tariff revenue of +£0.7bn (+1.7%) in 2022/23 from 2021/22. Across the sector, operating revenue increases by an average of +0.8% due to the tariff increases. The main driver of this change is the net effect of an uplift factor of +1.66% for inflation and efficiency.
   - Accident & Emergency (A&E) increases in tariff (+£0.28bn) accounts for almost half the increase in tariff revenue. All providers with an A&E department are expected to benefit from this.
   - The proposed change to move to the fourth year of the published five-year Market Forces Factor (MFF) transition path continues the lower tariff increases for the London region compared to the rest of the country.
   - The Aligned payment and incentive (API) approach, introduced for the 2019/20 national tariff, is the starting point for the 22/23 tariff proposals. We

do not expect the proposed API approach to have an undue negative impact on patient choice.

- We do not expect the 2022/23 NTPS proposal to have a material disproportionate impact on patients' base on different age groups, race or ethnicity

1.2 Scope of the analysis

9. For the 2022/23 NTPS, we propose to transition out of the emergency payment arrangements that were brought in at the start of the pandemic and continue the 2021/22 payment model where most 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. In addition, we propose to calculate unit prices, covering all services, using 2018/19 cost (PLICS) and activity (HES) data, introducing improvements in our methodology that improve transparency and cost reflectiveness. 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

10. Despite the move away from national prices, we considered that it would nevertheless be appropriate to assess the financial impact of the 2022/23 national and unit prices compared to the equivalent 2021/22 prices. This is because providers and systems may want to use the published prices when agreeing the fixed and variable payment elements.

11. For the purposes of this assessment, we have grouped the proposals for the 2022/23 NTPS into the following three areas:

    - **Rolling over 2021/22 policies –** we propose to continue with the 2021/22 aligned payment and incentive approach for almost all services.
    - **New prices –** we propose to calculate new prices based on 2018/19 cost (PLICS) and activity (HES) data.

[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 2022/23 NTPS. Available from: https://www.england.nhs.uk/pay-syst/national-tariff/consultation-on-2022-23-national-tariff/

- **Updates to existing policies –** MFF move to year 4 of the five-year glidepath. This transition was introduced in the 2019/20 NTPS.

12. In setting the 2022/23 national tariff, funding for COVID-19 costs have been excluded from tariff prices and calculations of inflation and efficiency, with funding to be distributed outside the tariff. In addition to direct costs, COVID-19 has had a significant impact on how care has been delivered, for example, an increase in virtual appointments. Many of these changes are not yet reflected in the data used to set the tariff.

13. It is therefore important to note that the proposed tariff and this impact assessment does not take into account costs relating to, or impact on activity from COVID-19. 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.

1.3 Our assessment approach

1.3.1 Appraisals overview

14. The emergency payment arrangements introduced as a result of the COVID-19 pandemic alongside the uncertainty about activity and costs, create an unusual context for this year's impact assessment. Recognising this, we have structured our assessment into two appraisals:

- **Appraisal A**: provides a brief qualitative assessment of the aligned payment and incentive blended payment model. See Section 2 for details.
- **Appraisal B**: quantitatively assesses the impact on provider income and commissioner expenditure, making the simplifying assumption that the scope of the tariff remained unchanged (i.e. we apply the simplifying assumption that the fixed element would be set by reference to the national prices and unit prices in the 2021/22 and 2022/23 tariff and that there will be no COVID-19 impact on activity, costs and prices). See Section 3 for details.

15. In Appraisal A, we consider the specific commitment in the NHS Long Term Plan to introduce a blended payment model for almost all services, specifically the aligned payment and incentive.

16. In Appraisal B, 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 2022/23 NTPS and is fully implemented. However, we note that the proposals for the fixed element do not specify that prices should be used in this way.

17. We nevertheless considered this appropriate because emergency payment block contracts for 2020/21 and 2021/22 were based on the historic outturn values for 2019/20, which were calculated using 2019/20 prices and supplemented by additional funding streams such as the financial recovery fund. On the assumption that all income is derived from national and unit prices, and that supplementary funding streams remain in place, we believe that this appraisal usefully presents the impact of our 22/23 policy proposals.

18. 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.

1.3.2 Approach to the appraisals

19. Appraisal A provides a qualitative assessment of the aligned payment and incentive blended payment model and impact on patient choice.

20. We have also assessed the likely impact of the proposed 2022/23 NTPS on patients and given due regard to our public sector equality duty under the Equality Act 2010,3 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 systems are likely to impact on the services provided and how the proposed 2022/23 NTPS is likely to impact on access to services and the quality of care

[3] 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.

provided. We also consider our proposals' likely impact on patient choice. See Sections 2 and 4 for details.

21. To measure the effect of the proposed 2022/23 NTPS on provider revenue, Appraisal B compares provider tariff revenue using the proposed 2022/23 prices against the equivalent 2021/22 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). We control for scale effects by expressing this difference in tariff revenue as a proportion of 2019/20 operating revenue.

22. We assess the aggregate impact of the 2022/23 NTPS proposals on NHS providers by type (acute, specialist, teaching and non-acute providers), NHS England commissioners and Integrated Care Systems.

1.4 Limitations and assumptions

23. 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 system expenditure, such as revenue streams from locally priced services that do not 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. Also, we do not capture planned changes in service provisions in integrated care systems (ICSs).

24. In addition, we 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. It is our intention to monitor and understand the implementation of the aligned payment during 22/23. This would be on an annual basis which would enable the information to be captured but not be a burden on the sector.

25. Our quantitative assessment is based on the following assumptions:

- **Duration of tariff** – we have assumed the tariff is in effect for a full year. The feedback from the engagement we carried out in September indicated that 75% of respondents were in favour of this.
- **Activity levels** – our base run uses 2018/19 activity levels and casemix. We consider this to be useful as our aim is to present the isolated impact of our proposed price changes. However, historic analysis of HES data alongside the backlog created due to COVID-19 would suggest an increased growth of activity. In this assessment, we have not made any adjustments for the significant impact that COVID-19 will have had on activity levels and mix. As a result, the actual impact of our proposals on tariff revenue and system expenditure is likely to be different from the impacts presented in this document.
- **Level of use** – our modelled scenario assumes that providers and systems 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 systems. 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.

26. The tariff is one part of the overall NHS financial framework. For 2022/23, with the overriding priorities of dealing with the COVID-19 pandemic, addressing the elective backlog that has built up during it and preparing for potential legislative changes in the Health and Care Bill, we are aware that the providers and commissioners are under a great deal of pressure and there may be limited capacity to undertake detailed negotiations about payments. We have therefore worked to develop a recommended methodology that can be used. (See Section 6 of *2022/23 National Tariff Payment System – A consultation notice*.)

1.5 Document structure

27. This rest of the document supports the statutory consultation notice on the proposed 2022/23 NTPS.[4] It is structured as follows:

[4] Available from: www.england.nhs.uk/pay-syst/national-tariff/consultation-on-2022-23-national-tariff/

- **Section 2** presents the estimated aggregate financial impact of the 2022/23 NTPS proposals on provider revenue and commissioner expenditure.[5]
- **Section 3** considers the qualitative factors of introducing the blended payment.
- **Section 4** considers the likely impact of our proposals in relation to the protected characteristics as described in the Equality Act 2010.
- **Section 5** 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.

[5] NHS England specialised commissioning and clinical commissioning groups (CCGs) or integrated care boards (ICBs), should ICBs become statutory organisations during the period the tariff is in effect.

2. Appraisal A – Qualitative assessment

2.1 Case for change – NHS payment system

28. The NHS Long Term Plan committed to reform the NHS payment system, with the aim of moving away from activity-based to population-based payment for NHS services. Activity-based payment (previously known as Payment by Results (PbR), then national tariff payment system) was initially introduced to reduce waiting times, support patient choice, reward efficiency and quality, and focus provider and commissioner/system discussions on quality rather than on price. While it has proved successful at delivering these objectives, the context and what the payment system needs to achieve has since evolved.

29. The primary driver for improvement within activity-based payment approaches is competition. However, in the context of Integrated Care Systems (ICS), the emphasis is shifting towards collaboration and how the payment system can support system partners to work together.

30. Prior to COVID-19, there was a mix of activity-based payments for acute services and block contracts for non-acute services. This approach was perceived as a barrier to innovation and integration, with various payment approaches driving different incentives, behaviours and risk allocations, and sometimes coming into conflict. Before the pandemic, local areas were increasingly moving away from national payment policy defaults and using block contracts, 'aligned incentive contracts' (AiC) and other payment approaches that best suit local health economy needs as explained below.

2.2 COVID-19 and payment

31. The NHS' response to COVID-19 meant that nationally set block payment arrangements were put in place for 2020/21 and 2021/22, rather than using an activity-based payment approach. While this payment approach has the benefit of simplifying the payment system moving decision-making from local

to national level. which was needed during the pandemic, it offers little transparency as to the efficacy and efficiency of payments in the system.

32. As the pandemic has progressed, providers have needed support to deliver increasing levels of non-covid activity, in addition to dealing with covid cases. As such, the Elective Recovery Fund was introduced in March 2021, giving additional income to providers to be able to deliver higher levels of elective activity, thereby helping to reduce patients' waiting list backlog.

33. The impact of COVID-19 and the financial arrangements introduced in response, have created a different starting point for payment system development to that envisaged in 2019/20 when blended payments was first introduced.

2.3 Blended payment

34. One of the specific commitments in the NHS Long Term Plan is to introduce a blended payment model for almost all services. Blended payment is intended to:

- Support a more effective approach through a fixed payment element as part of resource and capacity planning arrangements that focuses commissioners and providers in making the most effective and efficient use of resources to improve the quality of care and health outcomes.
- Provide shared incentives to local system partners to deliver the optimal level of care in the right place at the right time – and shared financial responsibility for levels of hospital activity.
- Fairly reflect the costs incurred by efficient providers in delivering care and generate incentives for continuous improvements in efficiency.
- Minimise transactional burdens, provide financial stability and reduce barriers to support service transformation.

35. Blended payment is designed as a framework, rather than a fixed design. It was initially introduced in 2019/20 for urgent and emergency care and adult mental health services. It was intended to then introduce it on a service-by-service basis over future tariffs, starting with outpatient and maternity services in 2020/21.

2.4 Aligned payment and incentive

36. Aligned payment and incentive (API) is a type of blended payment, introduced for the 2021/22 national tariff. It was designed to support a smooth transition out of the COVID-19 payment arrangements, while also making progress on developing the payment system.

37. The API model is the starting point for proposals being developed for the 2022/23 tariff. The API blended payment involves:

    - Providers and commissioners locally agreeing a fixed element to deliver an agreed level of activity.
    - A variable element to reflect quality of care (best practice tariffs and CQUIN) and address deviations from planned activity levels used to set the fixed element.
    - API arrangements cover almost all secondary healthcare services, which includes acute, community, ambulance and mental health.

38. API has been designed to cover the whole system (which includes MFF), looking at:

    - Fixed element based on improved cost data and more accurate activity forecasts aligned to ICS plans
    - Variable element based on understanding the costs of activity above and/or below plan
    - Simplification of specific quality-related payments
    - Agreed plans for how resources flow around the system, aligned to care models

39. All NHS England Specialised Commissioning is covered by API blended payment model (regardless of its value). For all other contracts, an annual value of £30m is the threshold for API agreements. This includes acute, community, mental health and ambulance services. Contracts under the Increasing Capacity Framework agreement for elective activity would again be exempted from the API blended payment. With a threshold of £30m, the total value of activity captured by aligned payment and incentive agreements would remain broadly the same as in 2021/22. The £30 million threshold for the merged CCG footprints and the proposed ICB (Integrated Care Boards)

footprints is consistent with £10 million for the 2021/22 CCG footprints. We feel that this stability would help embed the design of the payment system and also support monitoring of how aligned payment and incentive agreements are being reached between members of different ICSs. The threshold level would be considered again for 2023/24.

40. In 2022/23, API is the default payment approach for intra-ICS NHS contracts. API applies to all contracts for secondary healthcare services between commissioners and providers, who are members of the same Integrated Care System (ICS). For providers and commissioners in different ICSs:

    - API applies to all commissioned activity above a contract value threshold. For 2022/23, this threshold is set at £30 million.
    - Payment arrangements for contracts below this threshold would be determined by agreement between commissioners and the provider. Where agreement cannot be reached, prices published as part of the tariff are the default approach.

41. The introduction of API means that most prices published as part of the tariff are no longer 'national' (mandated) prices but are 'unit' prices instead. National prices remain for unbundled diagnostic imaging services. Unit prices are calculated in the same way as national prices but would be used in the variable element, as benchmarks, for some activity outside of the scope of API, and for independent sector activity delivered as part of the Increasing Capacity Framework. This means that unit prices would be used for around 5-6% of activity covered by the national tariff.

42. As we move towards establishing ICSs and a system by default principle, the fixed element of the API model represents the largest, single source of funding that systems can access and should be based on the best available costing data. Patient level costs (PLICS) will support systems to both set and spend their fixed element as well as increase intelligence with which fixed element will be set in future years.

2.5 Impact on patient choice

43. The aligned payment and incentive (API) approach is intended to support to service transformation, which includes the adoption of innovative ways of

working and increased system collaboration. However, as collaboration between providers increases, and with the focus on prioritising elective recovery of services following the pandemic, where the primary focus is on reducing the waiting list backlog, this approach may limit patient choice, although this is not the intention of the API approach. 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 do not expect the proposed API approach to have an undue negative impact on patient choice.

44. Overall, 2022/23 payment proposals make no distinction as to which providers should be commissioned to undertake patient care. However, it recognises the flexibilities that various payments approaches can bring, that are most appropriate for different contract values and the providers who hold these. The variable element also allows the system to adjust provider utilisation (choice) against assumptions in the system plan.

45. None of the proposals have been designed to reduce patient choice and we are not aware of any other information implying that the 2022/23 NTPS proposals would have disproportionate impact on patient choice. Consultees were invited to provide any comments or information which may assist with any further qualitative or quantitative assessment of impacts in relation to patient choice.

2.6 Engagement with sector

46. We have engaged with providers, commissioners, representative bodies, and other appropriate stakeholders throughout the development of our proposals for the 2022/23 NTPS. We extended our use of online engagement workshops and webinars and during the process had almost 1,700 attendees who provided qualitative feedback. (See Section 4 of the *2022/23 National Tariff Payment System – a consultation notice.*)

3. Appraisal B – Anticipated aggregate impact of proposed policy changes

47. 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 2021/22 and the 2022/23. 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 and 2021/22 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 (e.g. the Financial Recovery Fund).

48. 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 2022/23 NTPS proposals on NHS providers and commissioners.

49. We start this section by discussing the outputs of our base model run which simulates tariff revenues for providers and tariff expenditure for ICSs for 2021/22 and 2022/23, using 2018/19 HES activity data. We apply a constant level of activity to both years when simulating tariff revenue and ICS expenditure to better understand the impact of proposed policy changes.

50. More details on how we propose to calculate 2022/23 prices are available in Section 8 of Part A of the consultation notice and Annex DtD.

3.1 Anticipated aggregate impact of all 2022/23 proposals on NHS providers

51. Figure 1 below shows the combined impact of our proposals for 2022/23 on tariff revenue for NHS providers and reflects the effects of changes in prices under our scenario assumptions – i.e. it shows the difference between what a provider type would receive in 2022/23 using the proposed 2022/23 prices when compared to 2021/22 prices.

52. This scenario shows total tariff revenue increasing from around £39.2 billion to around £39.9 billion, which is an increase of +£0.7bn (+1.7%) in 2022/23 from 2021/22. Across the sector, operating revenue increases by an average of +0.8% due to the tariff increases. The main driver of this change is the net effect of an uplift factor of +1.66% for inflation and efficiency.

53. Most acute provider types (Acute Large, Acute Medium, Acute Multi Service and Acute Small) see above average gains in tariff revenue as a proportion of operating revenue. This ranges from +0.98% to +1.24%. (The average change in tariff revenue, as shown in Figure 1, is around +0.8% as a proportion of 2019/20 operating revenue).

Figure 1: Total Tariff difference by NHS provider type

Provider Type	Total Tariff Income (£'m) - 2021/22	Total Tariff Income (£'m) - 2022/23	Total Tariff Difference (£'m)	Percentage Difference (Total Tariff)	Tariff Difference as a % of Operating Revenue (%)
Acute - Large	£9,514.20	£9,683.31	£169.11	1.78%	0.98%
Acute - Medium	£5,225.58	£5,316.51	£90.92	1.74%	0.99%
Acute - Multi-Service	£826.68	£848.17	£21.49	2.60%	1.24%
Acute - Small	£4,128.75	£4,218.28	£89.53	2.17%	1.21%
Acute - Specialist	£1,431.41	£1,442.07	£10.65	0.74%	0.28%
Acute - Teaching	£17,833.22	£18,100.66	£267.44	1.50%	0.76%
Non - Acute	£289.71	£307.93	£18.22	6.29%	0.21%
Total NHS Providers	**£39,249.56**	**£39,916.93**	**£667.36**	**1.70%**	**0.80%**

Provider Type.	Total Tariff Income (£'m) - 2021/22	Total Tariff Income (£'m) - 2022/23	Total Tariff Difference (£'m)	Percentage Difference (Total Tariff)	Tariff Difference as a % of Operating Revenue (%)
⊞ NHS Providers	£39,249.56	£39,916.93	£667.36	1.70%	0.80%
⊞ Independent Providers	£1,517.03	£1,563.05	£46.02	3.03%	
Total	**£40,766.60**	**£41,479.97**	**£713.38**	**1.75%**	**0.80%**

54. The Acute teaching provider type will receive the largest increase due to tariff increase at £267.4m. However, this leads to a slightly lower than average increase as a percentage of operating revenue (+0.76% vs +0.80%).

55. There are 16 providers within the Acute Specialist provider type. Tariff has increased the least at +0.74%. There is great variability in this group ranging from -1.0% to +4.6% (See Figure 4).

56. The expected total tariff for 2022/23 is £41.5bn and this includes an anticipated £1.6bn for independent providers who are expected to receive a total tariff increase of £46m. As there is limited data available for independent providers, we have conducted our impact assessment on NHS providers who are expected to make up £39.9bn of the tariff for 2022/23.

Figure 2: Total tariff difference by NHS provider type and point of delivery

Point of Delivery	Acute - Large	Acute - Medium	Acute - Multi-Service	Acute - Small	Acute - Specialist	Acute - Teaching	Non - Acute	**Total**
Accident & Emergency	£75.60	£42.41	£6.28	£33.53	£3.44	£110.54	£8.29	**£280.09**
Daycase	£45.47	£25.43	£4.83	£20.16	£5.22	£73.04	£0.46	**£174.61**
Outpatient Attendance	£26.65	£13.96	£2.79	£12.50	£4.24	£51.46	£1.08	**£112.68**
Elective	£30.40	£15.87	£3.22	£14.36	-£3.97	£33.32	-£0.11	**£93.08**
Maternity	£12.00	£6.84	£0.82	£5.57	£1.44	£18.33		**£45.00**
Outpatient Procedure	£7.06	£5.18	£0.83	£5.64	-£1.14	£21.26	£0.07	**£38.89**
Unbundled	£7.04	£3.10	£1.05	£4.21	£0.22	£11.58	£0.35	**£27.55**
Non elective	-£35.10	-£21.86	£1.66	-£6.44	£1.21	-£52.09	£8.08	**-£104.55**
Total	**£169.11**	**£90.92**	**£21.49**	**£89.53**	**£10.65**	**£267.44**	**£18.22**	**£667.36**

57. For Acute and Non-Acute providers, the total tariff income will increase by £667m. The single largest element of this is Accident & Emergency which increases by £280m. This has been driven by the Emergency Medicine HRG (Health Resource Group) subchapter code VB. The next two significant elements are daycase, up £175m and outpatients, up by £113m.

58. The pattern of high A&E and daycase increases is expected to be seen across most Acute provider types (Large, Medium, Multi-Service, Small and Teaching) which covers 123 NHS providers.

59. Daycase will have the next highest increase in tariff at £175m. This is due to increases in a variety of HRGs (e.g. JC43C – minor skin procedures, AA30F – multiple sclerosis). It is not as uniform across the acute providers as the A&E increases and will vary depending on the provider and daycase case mix speciality. For example, some acute providers are expected to have a significant increase in daycase skin procedure tariff (JC43C) but not in multiple sclerosis (AA30F) and vice versa.

60. Outpatient attendance is expected to increase by £113m. The main driver here relates to an increase in the Cardiology outpatients (code 320 e.g. ECG stress testing). This is seen in all acute provider and those acute specialists that specialise in cardiac procedures.

61. The main driver of the decrease in Non-elective (-£104m) is the reduction in an HRG relating to complex stroke (AA35A). Across the Acute provider sector this one HRG is expected to decrease by £51m. Note there is hardly impact within the Acute Specialist sector for this code, just -£7k.

62. The Acute Specialist sector are expected to benefit the least from the A&E tariff increase. Providers in this sector tend not to have an A&E department. The three largest providers in the Acute Specialist sector, Great Ormond Street Hospital, The Royal Marsden, and The Christie do not have an A&E department.

3.2 Anticipated aggregate impact of all 2022/23 proposals on non-acute NHS providers

63. Our analysis suggests that, for NHS non-acute providers, 2022/23 NTPS proposals are likely to have the largest percentage increase in tariff revenues at +6.3% (compared to the average of +1.7%). However, this translates to only a +0.2% increase in operating income. The reason for this is that the non-acute sector has a small proportion of operating revenue that is directly impacted by changes in tariff income.

64. Sensitivity analysis indicates that for a 1% increase in tariff income, the non-acute operating revenue will only rise by 0.03%; the sensitivity is very low. Contrast that to the Acute sector which indicates over a 0.5% rise in operating income for every 1% increase in tariff income. This is more than fifteen times sensitive than the non-acutes and reflects the much higher proportion of tariff related incomes in acute providers.

3.3 Anticipated aggregate impact of all 2022/23 proposals by type of providers

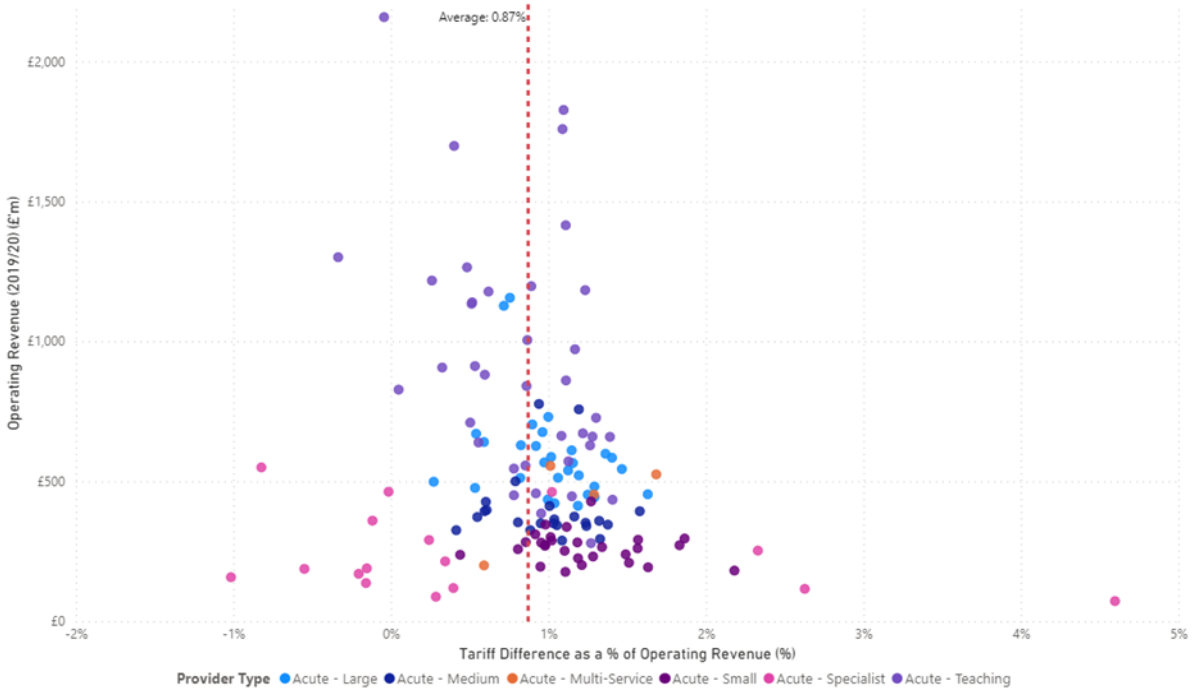
65. We expect that most acute providers (small, medium, large, teaching and multi-service) would benefit from our proposals for 2022/23. They represent the largest proportion of overall national and unit prices revenue and therefore receive a greater share of the overall increase in tariff revenue resulting from the adjustment for cost uplift and efficiency. The table in figure 3 below indicates that within this group, 84 out of 123 NHS providers will have an above average tariff gain.

66. The Acute Specialist sector has more providers with below average tariff gains, at twelve. This will be due to missing the significant A&E tariff increases and reductions in HRG subchapters which have a greater impact on some specialists due to the case mix. Note that three Acute Specialists have operating revenues gains of over 2%, this is well above the average of 0.9%. (See figure 4).

Figure 3: Number of NHS providers, excluding non-acute, that are above or below the average change in tariff revenue

Provider Type	Above Average	Below Average	Number of providers
Acute - Large	21	8	29
Acute - Medium	16	7	23
Acute - Multi-Service	3	1	4
Acute - Small	25	3	28
Acute - Specialist	4	12	16
Acute - Teaching	19	20	39
Total	**88**	**51**	**139**

Figure 4: Overall impact of 2022/23 NTPS proposals on tariff difference as a percentage of operating revenue for NHS providers, excluding non-acute



67. Most NHS providers are expected to have an above average increase in tariff income as a percentage of operating revenue (88 out of 139). This is especially true for the Acute Small providers (dark purple dots).

68. The Acute Large, Medium and Small providers (84 in total) all fall between +0.3% and +2.1%, a spread of 1.8%. Contrast this to the Acute Specialist providers which have a spread of 5.6% for only 16 providers. This reflects the variable nature of this sector and differences in case mix work.

69. The Acute Teaching providers are evenly split above and below the average (19 vs 20), however all the London based providers (8 in total) will have increases below the average. The main factor influencing this is the year 4 of the 5-year MFF transition path. This regional difference between London and out of London can be seen further in figure 6 below.

3.4 Anticipated aggregate impact of all 2022/23 proposals by ICS

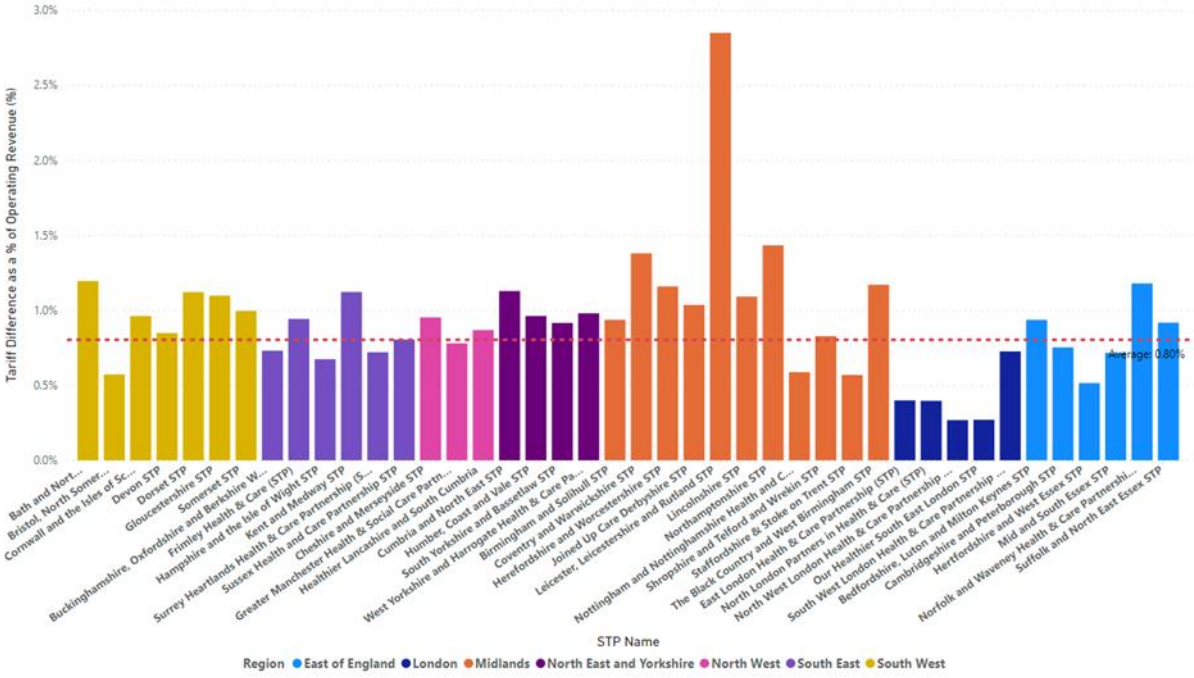
70. Here we present the impact of our proposals on systems (ICSs where applicable). We do this by aggregating provider 2019/20 operating revenue and proposed change in tariff revenue for 2022/23 for each ICS and calculate the overall change as an absolute figure and as a percentage of aggregated 2019/20 operating revenue.

71. The results seen in Figure 5 below include non-acute providers to ensure we get the most accurate impact at ICS level. Calculating at the 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 +0.80%.

72. Overall, 64% (27 of 42) of the ICSs are anticipated to see above average (around +0.80%) change in tariff revenue as a percentage of aggregated 2019/20 operating revenue.

73. The chart indicates that the London region ICS are anticipated to see well below the expected average tariff impact gains at +0.38%. This is due to year 4 MFF transition on providers and that London ICSs contain a higher proportion of Acute teaching providers compared to the rest of the country. Of the eight largest NHS providers impacted by tariff (operating revenue greater than £1.2bn), all are acute teaching providers and five are based within London. (The three out of London are in the next three largest UK cities, Manchester, Birmingham, and Leeds).

Figure 5: Overall impact of 2022/23 NTPS proposals on tariff revenue for NHS providers (acute and non-acute) by ICS



3.5 Anticipated aggregate impact of all 2022/23 proposals by region

74. Figure 5 above also shows the aggregated impact of our proposals for 2022/23 on NHS providers by region. The main factor within regions is the move to year 4 of the 5-year MFF transition.

75. Based on our analysis, we expect the 2022/23 proposals to have the greatest positive impact on the Midlands and the North East and Yorkshire Regions. These regions are likely to see above average tariff revenue increases of around +1.0% as a proportion of 2019/20 operating revenue. This is in line with prior year impact of the tariff proposals. We also expect to the proposals to have a positive impact on the South West region with an above average increase in tariff revenue of around +0.93%. The North West region is expected to see an increase in tariff revenue of +0.86% as well as the South East and the East of England regions, both with expected increases in tariff revenue of around +0.82%.

76. Our analysis indicates that London providers are, on average, likely to see a less than average increase in tariff revenue as a percentage of 2019/20

operating revenue with the London region expected to see an average change of 0.38%.

3.6 Anticipated aggregate impact of all 2022/23 proposals on commissioner spending

77. The expected impact of the 2022/23 NTPS proposals on commissioner spending is seen in figure 6 below.

78. 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.

79. Tariff expenditure by CCGs is expected to grow overall by about £0.7bn (1.96%).

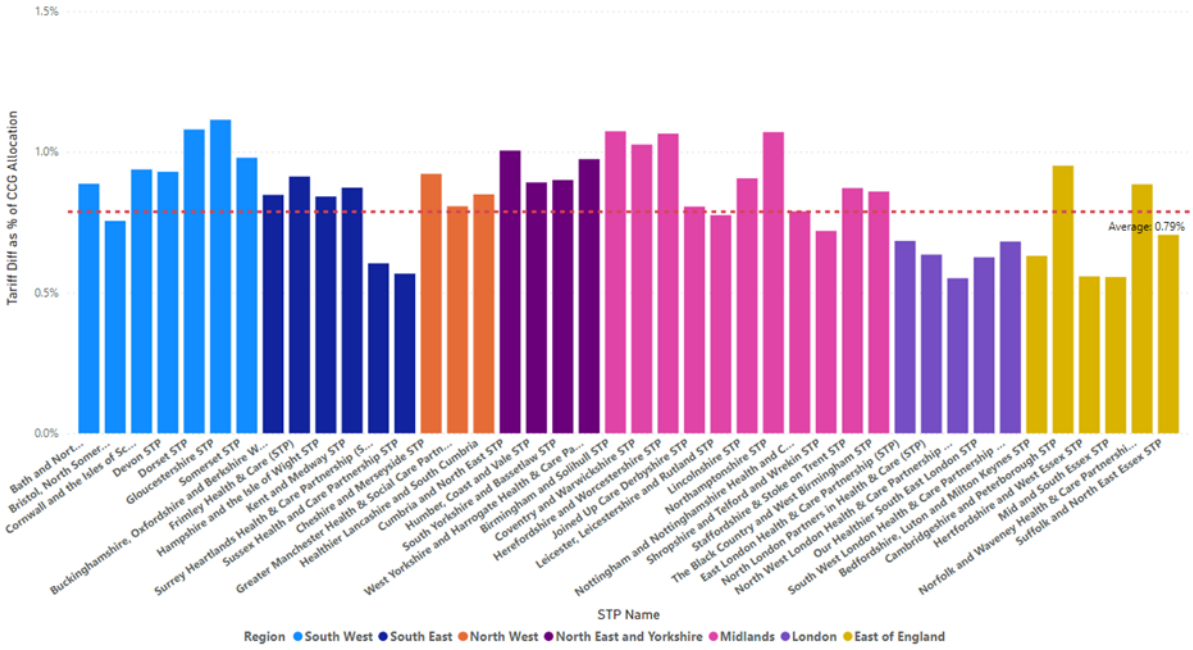
Figure 6: Overall impact of 2022/23 NTPS proposals on commissioner spending for local and central commissioners

Tariff Payment (£'m) - 2022/23, Tariff Payment (£'m) - 2021/22, Tariff Payment Diff (£'m), Percentage Diff (Tariff Payments)
BY CCG TYPE

CCG Type	Tariff Payment (£'m) - 2021/22	Tariff Payment (£'m) - 2022/23	Tariff Payment Diff (£'m)	Percentage Diff (Tariff Payments)
CCGs	£35,700.42	£36,400.10	£699.68	1.96%
NHS England Armed Forces and Prisoners	£55.00	£56.77	£1.78	3.23%
NHS England Specialised Services	£3,462.02	£3,446.37	-£15.64	-0.45%

80. Figure 7 below shows the impact by ICS(STP) and region for expected CCG expenditure as a percentage of 2021/22 allocation. The impact in anticipated tariff expenditure is mainly driven by the net effect of an uplift for inflation and efficiency, as well as proposed changes to MFF, with the proposed move to the fourth year of the MFF glidepath.

Figure 7: Change in tariff spending as a percentage of CCG 2021/22 allocations by ICS



81. The impact by ICS for CCGs is expected to differ from that for providers because of services commissioned by CCGs from outside their ICS and providers also receiving income from outside their ICS.

82. Our analysis indicates that at an ICS level, aggregate CCG tariff spending as a percentage of allocations is expected to increase by an average of 0.79%. Commissioners in the London region are likely to see a below average increase in their tariff expenditure as a result of the move to the fourth year of the MFF glidepath. Commissioners in the Midlands, South West, North West and the North East and Yorkshire regions are anticipated to see an above average increase in their tariff expenditure.

4. Impacts relating to equality

4.1 Overview

83. Under Section 149 of the Equality Act 2010 (Equality Act), NHS Improvement (Monitor) 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.

84. 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.

85. 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 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.

4.2 Methodology

86. 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 2022/23 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.

87. Patient age, race and gender are recorded in the 2018/19 Hospital Episode Statistics (HES) data set which is independently quality assured by NHS Digital. The use of this HES dataset enables us to quantify how the proposed 2022/23 unit prices would likely affect spending on patients by these protected characteristics. We have also considered the potential impact of our proposals on these groups qualitatively. Information concerning the remaining equalities characteristics are not currently recorded in HES, for groups with these characteristics we have therefore only assessed the likely impact of our proposals qualitatively.

4.3 Assessment

4.3.1 Age

88. 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 unit prices would increase spending for all age groups by between 0.49% to 3.56%.

89. We therefore do not expect the 2022/23 NTPS proposal to have a material disproportionate impact on different age groups.

90. Figure 8 shows the anticipated change in spending for the different age groups, where the age field was populated in HES.

Figure 8: Anticipated changes in tariff income by age group

Age group	Tariff Income (£'m) - 2021/22	Tariff Income (£'m) - 2022/23	Difference in Tariff Income (£'m)	% Difference in Tariff Income
0-18	£4,062.64	£4,207.11	£144.47	3.56%
19-65	£17,896.43	£18,352.37	£455.95	2.55%
Over 65	£16,908.05	£16,990.48	£82.43	0.49%
Unknown	£1,899.48	£1,930.01	£30.53	1.61%
Total	**£40,766.60**	**£41,479.97**	**£713.38**	**1.75%**

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

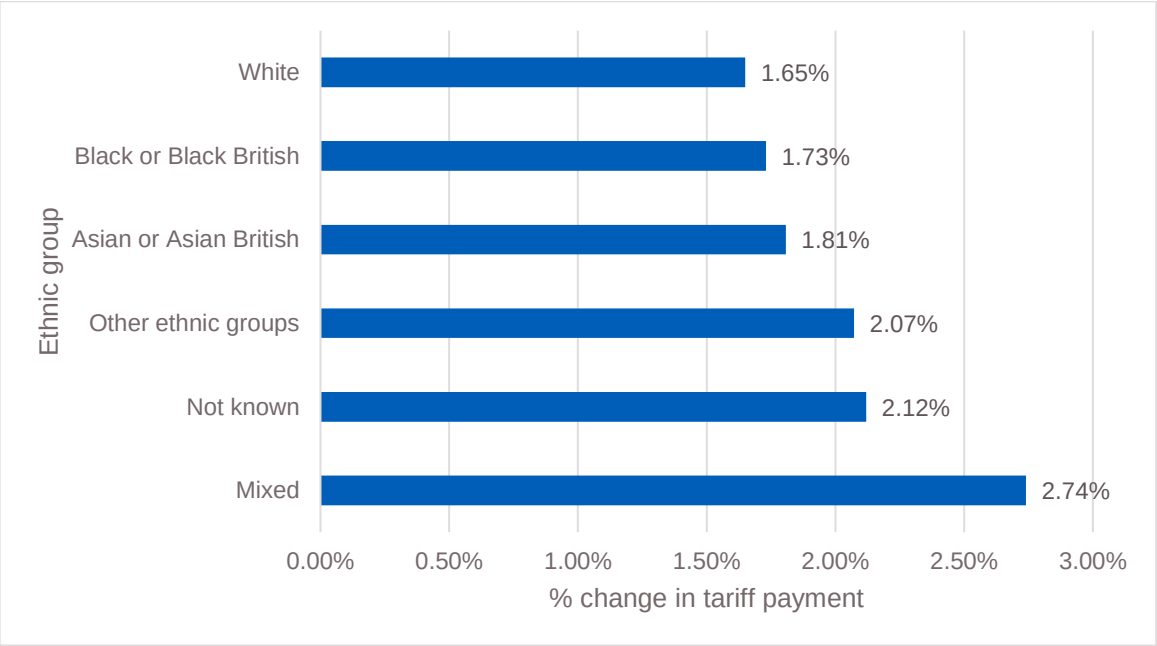
91. The NTPS does not distinguish between patients based on their race, ethnicity or nationality. However, there are health conditions that are disproportionately experienced by people from certain ethnic groups and so the NTPS could have a disproportionate impact on different ethnic groups.

92. Based on our assessment, the proposed NTPS prices would increase spending by between 1.65% and 2.74% for all ethnic groups, as illustrated in Figure 9 below.

93. We therefore do not expect the 2022/23 NTPS proposals to have a material disproportionate impact on patients based on race, ethnicity or nationality.

94. Our assessment indicates the lowest increase in tariff in the London region (figure 5) and this region also has the highest proportion of population from a non-white ethnic group. A review of the anticipated changes in tariff by ethnicity in London indicates a pattern broadly in line with the national picture shown in figure 7. In London, the white ethnic group is due to have a +0.75% increase with the mixed ethnic group expected to have a +1.99% increase. The assessment does not indicate a disproportionate impact in London based on race, ethnicity or nationality.

Figure 9: Anticipated changes in tariff payment by ethnicity



4.3.3 Gender

95. Certain procedures are, by their nature, specific to male and female patients and there are HRG chapters with gender-specific procedures. Based on assessment of the available data, we estimate that the proposed unit prices would increase spending only slightly more for female patients (Figure 10). We therefore do not expect the 2022/23 NTPS proposal to have a material disproportionate impact on men or women.

Figure 10: Anticipated changes in tariff payment by gender

Gender	Tariff Income (£'m) - 2021/22	Tariff Income (£'m) - 2022/23	Difference in Tariff Income (£'m)	% Difference
Female	£21,254.32	£21,674.28	£419.96	1.98%
Male	£17,933.50	£18,196.55	£263.05	1.47%
Not known	£7.21	£7.37	£0.16	2.16%
Not specified	£1,571.57	£1,601.78	£30.21	1.92%
Total	**£40,766.60**	**£41,479.97**	**£713.38**	**1.75%**

4.3.4 Pregnancy and maternity

96. The 2022/23 NTPS proposals would increase spending on maternity by 1.94% (£45.0 million). We are not aware of any information that would suggest that the 2022/23 NTPS proposals would have a disproportionate impact on this group of patients.

4.3.5 Sexual orientation

97. The national tariff does not distinguish between patients on the basis on their sexual orientation. We do not hold statistics on the sexual orientation of patients and are not aware of any information that would suggest that the 2022/23 NTPS proposals would have a disproportionate impact on patients by sexual orientation.

4.3.6 Marriage and civil partnership

98. The national tariff does not distinguish between patients based on their marital or civil partnership status. We are not aware of any information that would suggest that the 2022/23 NTPS proposals would have a disproportionate impact on patients by marriage or civil partnership status.

4.3.7 Gender reassignment

99. Gender reassignment is a specialised service provided by the NHS. The national tariff does not distinguish between patients based on gender reassignment, and we do not currently have data available that would allow us to quantify any such impact. We are not aware of any other information that would suggest that the 2022/23 NTPS proposals would have a disproportionate impact on this group of patients.

4.3.8 Disability

100. The HRG4+ phase 3 currency design enables us to distinguish between care provided to patients with different levels of complexity to reflect the expected higher use of resources to treat patients who do have complications and comorbidities. Comorbidities can be associated with disability, and therefore this currency design helps to ensure that providers are more appropriately reimbursed for providing care to patients with disabilities. We are not aware of

any other information that would suggest that the 2022/23 NTPS proposals would have a disproportionate impact on this group of patients.

4.3.9 Religion or belief (including lack of belief)

101. The national tariff does not distinguish between patients based on their religion, belief, or lack thereof. We are not aware of any information that would suggest that the 2022/23 NTPS proposals would have a disproportionate impact on this group of patients.

4.3.10 Other considerations

102. While some of the 2022/23 NTPS proposals may potentially have an impact on certain patients with protected characteristics, the rules on locally determined prices give systems and providers the flexibility to agree local payment approaches or prices to mitigate any unintended consequences of our proposals. We also expect providers and systems to take the necessary steps to ensure they comply with the equality duty when designing and/or commissioning services.

103. We have also considered the impact of our proposals on health inequalities, however due to lack of available data we have been unable to quantify any potential impacts. We have however qualitatively reviewed our proposals' impact on health inequalities and have not identified any significant unmitigated concerns. We continue to review the availability of datasets that will enable us to assess any such impacts for future tariffs. Furthermore, consultees are invited to provide comments or information which may assist with further qualitative or quantitative assessment of impacts in relation to health inequalities.

5. Conclusion and next steps

104. Our analysis in appraisal B shows that there is an increase in tariff revenue of +£0.7bn (+1.7%) in 2022/23 from 2021/22.

105. The main driver of change in tariff revenue from 2021/22 to 2022/23 for NHS providers is the net effect of an uplift factor of +1.66% for inflation and efficiency

106. We estimate that for NHS providers 2022/23 tariff revenue as a proportion of 2019/20 operating revenue would range from –1.0% to +4.6%, with an average of +0.9%.

107. Over the course of the 2022/23 tariff, we are planning to monitor and review policies, to inform future pricing policy development.

6. Appendix 1: NHS Improvement's statutory duties

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

109. 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[6] would secure the discharge of its duties under Sections 62 and 66 of the 2012 Act.

110. 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 2022/23 NTPS proposals would secure the discharge of these statutory duties and,
- where appropriate, how NHS Improvement has complied with its duties in developing the 2022/23 NTPS proposals.

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

6 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.

6.1 Section 116(13) of the 2012 Act

6.1.1 Section 62(1): Protect and promote the interests of patients[7]

112. 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.

113. We explain how the 2022/23 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.

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

114. NHS Improvement's and NHS England's method for setting national prices and unit prices[8] follows two main principles:

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

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

116. We consider that the 2022/23 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.

117. The aligned payment and incentive approach supports a more effective approach to capacity and resource planning, providing shared incentives for managing demand, which better supports service transformation and integrated care. The fixed element of the payment approach would enhance

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

8 NHS Improvement and NHS England's method for setting national prices and unit prices is set out in Section 8 of the consultation notice, Section 6 of the draft 2022/23 NTPS and Annex DtD.

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. This should ensure that patients can access new models of care, and that 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.

118. 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 (Clinical Negligence Scheme for Trusts) uplifts in tariff are set with the intention that it incentivises trusts to reduce clinical negligence costs.

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

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

121. 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.

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

123. 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 providers are able to include BPTs in the fixed and variable element.

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

124. 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 (e.g. BPTs).

125. 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, thereby supporting 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.

126. 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.

127. 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.

128. 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

129. 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.

130. 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.

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

131. 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.

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

133. 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 where appropriate.

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

6.1.5 Section 62(3): Competition

135. 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:

- The use of 2018/19 patient-level cost (PLICS) data to calculate the 2022/23 price relativities.
- Market forces factor
- The aligned payment and incentive approach

136. We have looked at whether the 2022/23 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.

Calculating 2022/23 price relativities using 2018/19 patient-level cost (PLICS) data

137. In setting the proposed 2022/23 prices we have used 2018/19 patient-level cost (PLICS) data. We also make adjustments that affect the level of all prices (i.e. inflation, CNST, and efficiency).

138. 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).

139. We therefore do not expect the proposal 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

140. The proposed change to move to the fourth 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 fourth 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

141. 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.

142. 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.

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

144. 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

145. 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

146. 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.

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

147. 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.

148. 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.

6.1.7 Section 62(7): Patient and public involvement

149. We undertook a range of consultation and engagement activities as part of developing the 2022/23 NTPS proposals.

150. 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 participating in the September 2021 engagement workshops on the 2022/23 national tariff.[9] In addition, we held webinars on our proposals during September 2021, which were free for anyone to attend.

9 NHS England » Developing the national tariff

151. 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.

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

6.1.8 Section 62(8): Clinical and public health advice

153. 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.

154. During the development of these proposals we engaged extensively with the Expert Working Groups (EWGs)[10] run by the National Casemix Office, in addition to other clinical stakeholders 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.

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

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

[10] 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

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

157. 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 (e.g. public health services) or an existing payment mechanism (e.g. 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.

158. 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.

159. 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.

6.1.10 Section 62(10): Non-discrimination between providers

160. 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.

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

6.2 Section 116(13) of the 2012 Act

162. 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.

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

163. 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.[11] The considerations set out in relation to Section 62(1)(b) of the 2012 Act (quality – see Section 6.1.3 of this Appendix) are also relevant.

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

165. 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 (Care Quality Commission).

6.2.2 Section 66(2)(a): Continuous improvement in quality

166. We have had regard to the risk to continuous improvement in quality when setting our proposals. Our proposals support continuous improvements in the

[11] See Section 8.6 of Part A of the consultation notice.

quality of care and services. In particular, the aligned payment and incentive approach allows radical redesign of patient pathways and redistribution of hospital specialties, ensuring that elective recovery of services is not shaped by income generation but by local health and care strategic plans and by the need to address health inequalities.

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

168. 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 6.1.1 above) are also relevant.

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

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

170. Section 6.1.2 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, API 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.

171. 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. 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.

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

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

173. 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 (National Institute for Clinical Excellence) 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.

174. Pricing rules for locally determined prices allow for local variations which, for example, promote service integration (e.g. pathway payments). 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.

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

175. 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.

176. 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.

177. 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.

6.2.6 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)

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

6.3 Section 116(13) of the 2012 Act

179. 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.

180. 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.

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

6.4 Section 119 of the 2012 Act

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

6.4.1 119(1): Fair level of pay for providers of healthcare services and having regard to differences between providers

183. 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.

184. 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.

185. 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 fourth year of the published MFF values would further contribute to this aim.

186. 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.

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

188. 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.

189. 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.

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

190. A system of national currencies is one of the building blocks of the payment system for NHS care. For 2022/23, 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.

191. 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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