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2023/25 NHS Payment Scheme – a consultation notice

Part C: Impact assessment

23 December 2022

This is part of the consultation notice for the 2023/25 NHS Payment Scheme. The consultation notice has three parts:

- Part A – policy proposals.
- Part B – draft NHSPS.
- **Part C – impact assessment.**

The consultation notice documents, as well as annexes and supporting documents, are available from: www.england.nhs.uk/publication/2023-25-nhsps-consultation/

Contents

1. Impact assessment

1.1 Purpose

1. This document presents our assessment of a likely impact of implementing NHS England's proposals for the 2023/25 NHS Payment Scheme (NHSPS). It should be read alongside Part A of the *2023/25 NHS Payment Scheme – a consultation notice*[1] which provides full details of our proposals. The aim of this document is to help providers, Integrated Care Boards (ICBs) and other consultees understand a likely impact of our policy proposals. This should support planning and help inform responses to the 2023/25 NHSPS statutory consultation.

2. 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. For the 2023/25 NHSPS, we are proposing four different payment mechanisms covering the provision of NHS-funded secondary healthcare services.

3. In the consultation notice we present the details of each of our policy proposals, explaining why we think this is the right thing to do. In this document, our aim is to provide an overall qualitative assessment of the 2023/25 NHSPS proposals and a quantitative assessment of the estimated aggregate impact of the NHSPS prices under a simplified scenario.

4. In detail, this document covers:

    - a qualitative assessment of the proposed 2023/25 NHSPS and a likely impact on patient choice (Section 2)
    - our estimated aggregate financial impact of the proposed 2023/25 NHSPS prices on provider revenue and commissioner expenditure (Section 3)
    - a likely impact of the 2023/25 NHSPS proposals on equality (Section 4)

[1] www.england.nhs.uk/publication/2023-25-nhsps-consultation/

5. The NHSPS proposals which are the subject of this assessment are subject to consultation. The statutory consultation period is 28 days, ending on 21 January 2023. 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 **27 January 2023**. For further details on how to respond, please see the Part A of consultation notice.

1.2 Scope of the analysis

6. For the 2023/25 NHSPS we propose to apply four different payment mechanisms:

Payment mechanism	Brief description	Applies to
Aligned payment and incentives (API)	Fixed element, with variable element for elective activity	Almost all NHS provider relationships with • NHS England for any directly commissioned services; and • with any ICB not covered by LVA arrangements
LVA block payments (for low volume activity)	Nationally set payment amounts to cover entire provider/commissioner relationship	Almost all NHS Trust or NHS Foundation Trust and ICB relationships for which NHS England has mandated an LVA block payment (this will normally be those with an expected value of annual activity of £0.5m or less, prior to inclusion of any services delegated by NHS England)
Activity-based payment	NHSPS unit price (with national variation applied) paid for each unit of activity	Services with NHSPS unit prices delivered by non-NHS providers
Local agreement	Providers and commissioners agree appropriate approach	Activity not covered by another payment mechanism

7. For the purposes of our quantitative assessment, we make the simplifying assumption that the fixed and variable elements are set by reference to the

NHSPS prices. The quantitative assessment focuses on 2023/24 prices found in Annex DpA, including the proposed changes in prices.[2]

8. The proposals of the 2023/25 NHSPS mean the 2024/25 NHSPS prices would be updated using revised cost uplift and efficiency factors, calculated via a formula. These figures are not yet available therefore this impact assessment does not consider the detailed quantitative impacts for 2024/25. However, since all revised prices would be subject to the same change the impact on expenditure and revenue would be uniform across all HRG sub-chapters[3].

9. For 2023/24, we consider our simplified assumption to be appropriate as our intention is to show a financial impact of the 2023/24 NHSPS prices compared to the equivalent 2022/23 prices. This is because providers and systems may want to use the published prices when agreeing the fixed element and elective activity[4] is paid for at a rate of 100% of NHSPS unit prices. However, we note that the proposals for the fixed element do not specify that prices must be used in this way, merely that it may be appropriate to do so.

1.3 Our assessment approach

1.3.1 Appraisals overview

10. We have structured our assessment into two appraisals:

- **Appraisal A**: provides a brief overall qualitative assessment of the NHS Payment Scheme proposals. See Section 2.
- **Appraisal B**: quantitatively assesses the impact on provider income and commissioner expenditure for 2023/24, making the simplifying assumption that the scope of the payment scheme remains unchanged to the 2022/23 National Tariff (i.e. we apply the simplifying assumption that the API fixed element would be set by reference to the NHSPS prices in 2023/24 and

[2,4] For more information on proposed price changes, see section 10 of Part A of the consultation notice

[3] Should we decide that some changes are needed for 2024/25, we could either consult on a new NHSPS or, under the 2022 Act, consult on specific amendments only (e.g. changes to the high cost drugs and devices lists)

[4] "elective activity" means the number of elective spells, first outpatient attendances, outpatient procedures which group to a non-WF HRG with a published HRG price, chemotherapy delivery and unbundled diagnostic imaging and nuclear medicine activity.

equivalent prices in 2022/23, and that activity and casemix are not materially affected from COVID-19). See Section 3.

11. As required in the Health & Care Act 2022, these appraisals provide an assessment of a likely impact of the proposed scheme.

1.3.2 Approach to the qualitative assessment

12. In Appraisal A, we consider the overall direction of the proposed 2023/25 NHSPS against the NHS Long Term Plan commitment to reform the payment system and provide an overall qualitative assessment of our proposals, including a likely impact on patients and the sector.

1.3.3 Approach to the quantitative assessment

13. In Appraisal B, we present a quantitative impact on NHSPS revenue and expenditure, and consider this for providers, ICBs and regions.

14. There is a simplifying assumption that the API fixed element is calculated as if using the 2023/25 NHSPS prices. In appraisal B we focus on the impact of price changes in the first year of the payment scheme where prices are available. In 2024/25, it is proposed that prices would be updated using revised cost uplift and efficiency factors, calculated via a formula. This would mean that updates would shift NHSPS prices globally by the same factor. For example, if the revised cost uplift factor for 2024/25 is ‘x’%, the 2024/25 NHSPS prices will be shifted globally by ‘x’%.

15. We consider our simplified assumption to be appropriate as the focus of our quantitative assessment is to present the isolated impact of our proposed price changes against a fixed level of activity and casemix.

16. We have also assessed a likely impact of the proposed 2023/25 NHSPS on patients and given due regard to our public sector equality duty under the Equality Act 2010[5], 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

[5] Under Section 149 of the Equality Act 2010 (Equality Act), 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.

commissioners are likely to impact on the services provided and how the proposed 2023/25 NHSPS 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 2 and 4.

17. To measure the effect of the proposed 2023/24 NHSPS on provider revenue, Appraisal B compares provider NHSPS revenue using the proposed 2023/24 prices against the equivalent 2022/23 prices. To calculate NHSPS 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).

18. We assess the aggregate impact of the 2023/25 NHSPS proposals on NHS providers by type (acute, specialist, teaching and non-acute providers) and on Integrated Care Boards and NHS England commissioners.

1.3.4 Quantitative assessment: limitations and assumptions

19. The scope of our quantitative assessment is limited to income and expenditure of activity that has an NHSPS price. We do not quantitatively assess other changes that may impact on provider revenue and ICB expenditure, such as revenue streams from locally priced services and revenues from outside the NHSPS. This is because of data limitations and our assessment being focused on NHSPS policy proposals. Also, we do not capture planned changes in service provisions in integrated care systems (ICSs).

20. In addition, we do not quantitatively assess how the API fixed element is going to be set in practice. We assess a likely impact using the simplifying assumption that prices are a reasonable way of estimating or indicating that likely impact. We are continuing our work with stakeholders to understand how systems are implementing the API payment mechanism and we are looking at ways to monitor the implementation of our proposals without adding a burden on the sector.

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

- **Duration** – our proposal is to set NHSPS for two years – 2023/24 and 2024/25. The 2023/24 prices are published alongside this consultation notice and the 2024/25 prices will be set to reflect revised cost uplift and efficiency factors, which would be updated using a formula[6]. For the purposes of this assessment, we focus on the first year of the payment scheme using the published 2023/24 NHSPS prices and assume the payment scheme is in effect for a full financial year.
- **Activity levels** – our baseline 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 under a given casemix. We recognise that actual 2023/24 activity data could be different to the activity levels and casemix used in our baseline. The impact of COVID-19 and other changes in clinical practice (e.g. increase in virtual appointments) are also very difficult to forecast. As a result, the true quantitative impact of our proposals on NHSPS revenue and commissioner expenditure could differ from the impacts presented in this document.
- **Level of use** – our modelled scenario assumes that providers and commissioners use the NHSPS prices for the fixed element. This assumption allows a comparison of our proposals on prices and the associated impacts on providers and commissioners. This is the equivalent of setting the fixed element of our proposed API payment using NHSPS unit prices and activity. Our consultation notice says that it may be appropriate to set the fixed element this way but also that it may not be. The more the elements of the agreed API approach differ from our assumption, the greater the difference between the impact of our quantitative findings and the local impact on systems.

1.3.5 Summary of quantitative findings

22. The quantitative findings of the impact assessment under our simplified scenario are:

    - For the first year (2023/24) of the NHSPS, we anticipate an increase in NHSPS priced revenue of +£0.7bn (+1.7%) from 2022/23. The main driver of this change is the net effect of the cost uplift and efficiency factors.

[6] For more information on setting the cost adjustment factors for 2024/25, see section 5.5 of Part A of the consultation notice

- There is an above average increase in revenue for maternity point of delivery (+4.2%) driven by changes in the Clinical Negligence Scheme for Trusts payments put through the NHSPS.
- For the second year (2024/25) of the NHSPS, we propose to update NHSPS prices using revised cost uplift and efficiency factors, calculated via a formula. This would mean that prices will shift uniformly and the estimated impact on NHSPS priced revenue would reflect the net effect of the cost uplift and efficiency factors.
- We do not expect the 2023/25 NHSPS proposal to have a disproportionate impact on patients based on different age groups, race, or ethnicity.

1.4 Document structure

23. The rest of this document supports the statutory consultation notice on the proposed 2023/25 NHSPS. It is structured as follows:

- **Section 2** provides an overall qualitative assessment of the proposed 2023/25 NHS Payment Scheme.
- **Section 3** presents the estimated aggregate financial impact of the 2023/25 NHSPS proposals on provider revenue and commissioner expenditure, under our simplified scenario.
- **Section 4** considers the likely impact of our proposals in relation to the protected characteristics as described in the Equality Act 2010.

2. Appraisal A – Qualitative assessment

2.1 The proposed 2023/25 NHS Payment Scheme

24. The Health and Social Care Act 2012 (as amended by the Health and Care Act 2022) replaces the National Tariff Payment System (NTPS) with the NHS Payment Scheme (NHSPS). In line with the NHS Long Term Plan commitment to reform the payment system, we are moving away from a purely activity-based payment system towards a more flexible population-based payment system. For 2023/25 we are proposing to set the rules for four payment mechanisms that will cover the amount payable for the provision of NHS-funded secondary healthcare services. The rules for each payment mechanism are designed to support each model of care to enable integration of services, increase elective activity and reduce the administrative burden on systems.

25. Our aim is to simplify the payment system and produce appropriate payment mechanisms that providers and commissioners can use to achieve their goals and support efficient use of available resources.

26. In the context of ICSs, the emphasis is shifting towards collaboration and how the payment system can support system partners to work together. In our Payment and the NHS Long-Term-Plan publication we outlined how a reformed payment system can contribute to system change and support integrated care.

27. Following the emergency payment arrangements that were in place for 2020/21 and 2021/22 in response to COVID-19, in 2022/23 we restored the National Tariff Payment System where the majority of secondary services, apart from diagnostic imaging that remained on national prices, were reimbursed using a blended payment model. This was intended to support ICSs to transition away from the emergency block payments to a payment approach that is more transparent into how available resources are being spent while continue to support system collaboration and integrated care.

2.2 Payment mechanisms

28. Activity delivered by NHS providers would either be delivered by API blended payments or low volume activity (LVA) block payments. The API payment mechanism is a blended payment model comprising of fixed and variable elements for almost all services, including acute, community, mental health and ambulance services. Blended payment is a framework, rather than a fixed design, intended to:

    - Support a more effective resource and capacity planning approach through fixed and variable elements that focus 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.

29. The LVA block payment arrangements are intended to reduce the burden of invoicing for relatively small amounts of money. NHS England would set an LVA payment value for all provider/commissioner relationships in scope (usually those with an expected annual value below £0.5m) – see Section 7 of the consultation notice.

30. For non-NHS providers, we propose an activity-based payment mechanism should be used for all services with an NHSPS unit price. This would reimburse providers for each unit of activity delivered. This is a payment mechanism that is well understood and widely used in the sector and will support the wider system goal to increase elective activity and reduce waiting times.

31. There is also a local payment arrangement mechanism, which would apply to any activity not covered by another payment mechanism (for example services delivered by non-NHS providers that do not have an NHSPS unit price).

32. The consultation notice sets out the detailed proposals for each of these payment mechanisms, and an assessment of why we think they are the right thing to do. This approach, including the proposed two-year duration that gives more certainty to systems, supports our goal for payment system reform and will enable ICBs to deliver integrated care and allocate their resources efficiently.

2.3 Engagement with the sector

2.3.1 Implementing a blended payment approach

33. For NHS providers, we propose two payment mechanisms – the API and LVA block payments as outlined above.

34. Throughout the development of our proposals we have engaged with a wide range of stakeholders and used this input to shape our policies.

35. Providers and commissioners are supportive of the direction of our payment reforms and move towards more system collaboration. Concerns have been raised though around an increase in complexity of managing the payment approach, especially between the interaction of the API rules and ERF funding. For 2023/25, our proposed approach should ensure that elective recovery funding is more straightforward and we are also proposing that elective activity above agreed targets is paid at 100% of NHSPS prices. From our engagement, providers raised concerns that the 75% variable rate would not reimburse their costs sufficiently and would also create a differential rate between NHS and non-NHS providers for delivering elective activity. Our proposal for 100% NHSPS prices paid for elective activity above agreed targets will ensure providers have the resources they need to deliver the extra activity.

36. In addition, we are proposing to remove the £30m threshold (below which API does not apply for providers and commissioners in different ICSs) that existed in 2022/23 NTPS, making the API arrangements the default payment mechanism for all NHS provider/commissioner relationships that are not subject to LVA arrangements. In our July engagement workshops, we received mixed views about this approach with concerns raised over the potential administrative burden of an increased number of API contracts for relatively small amounts of money. However, considering the smaller number

of NHS commissioning organisations (following the passage of the 2022 Act and establishment of ICBs), and our proposal for LVA arrangements, we do not expect this to result in a significant increase in administrative burden.

37. Finally, from our wider engagement concerns were raised that moving to a blended payment approach could impact coding quality and reduce the emphasis on data accuracy. As a result, we are proposing to include data quality in the payment principles that are applied in all payment mechanisms in NHSPS. We believe this will further highlight the importance of using complete and accurate data and will ensure systems are continuing to prioritise data quality. As part of the National Cost Collection there are new data quality metrics being added to the Data Quality Dashboard. In addition, the 2022 Act strengthens provider licence conditions relating to the coding, counting and costing of activity data.

38. Overall, we expect the 2023/25 NHSPS proposals to continue supporting our aim for payment reform while enabling ICSs to work collaboratively to deliver their goals. More details for each of our proposals alongside 'why we think this is right thing to do' can be found in Part A of the consultation notice.

2.3.2 Impact on patient choice

39. The proposals for the 2023/25 NHSPS are intended to support service transformation, which includes the adoption of innovative ways of working and increased system collaboration. However, as collaboration between providers increases and ICSs focus on reducing the elective waiting list backlog, there is a risk for patient choice to be limited. However, this is not the intention of the NHSPS proposals and 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 payment scheme to have an undue negative impact on patient choice.

40. Overall, 2023/25 NHSPS proposals make no distinction as to which providers should be commissioned to undertake patient care. However, it recognises the flexibilities that various payment approaches can bring, that are most appropriate for different contract values and the providers who hold these. The variable element for example allows the system to adjust provider utilisation (choice) against assumptions in the system plan and LVA arrangements are

expected to reduce the transactional burden for small values of activity allowing providers to focus on delivering patient care.

41. None of the proposals have been designed to reduce patient choice and we are not aware of any other information implying that the 2023/25 NHSPS proposals would have disproportionate impact on patient choice.

2.3.3 Feedback from stakeholders

42. We have engaged with providers, commissioners, representative bodies, and other appropriate stakeholders throughout the development of our proposals for the 2023/25 NHSPS. We extended our use of online engagement workshops and webinars, had regular discussions with representative bodies and held various co-design sessions with stakeholders and clinical groups.

43. In section 4 of the Part A of the consultation notice we explain in more detail how we worked with stakeholders to develop our proposals and in the following sections of the notice we present the feedback received during our July engagement workshops for each of our policies and explain how we have used this to develop our proposals.

44. Consultees are invited to provide any comments or information which may assist with any further qualitative or quantitative assessment of impacts of our proposals

3 Appraisal B – Anticipated aggregate impact of proposed policy changes

45. This section presents the overall impacts of the policy proposals using the approach and simplifying assumptions set out in sections 1.3.3 and 1.3.4. In this scenario, our assessment considers the impacts on NHSPS priced revenue and expenditure, assuming the scope of the NHSPS remains unchanged between the 2022/23 National Tariff and 2023/24. It also assumes that the API fixed element is calculated as if using the NHSPS prices. As set out in sections 1.3.3 and 1.3.4, we consider this analysis to be appropriate as the goal of our quantitative assessment is to present the isolated impact of our proposed price changes against a fixed level of activity and casemix.

46. The findings presented in this appraisal represent the aggregate impact for the first year (2023/24) of the 2023/25 NHSPS policy proposals on providers and commissioners.

47. Findings for the second year (2024/25) are not presented in detail as these will depend on adjustment factors (2024/25 cost uplift and efficiency) which are not yet available. However, our proposal to adjust the 2024/25 NHSPS prices using a formula means the prospective adjustment will update prices uniformly to reflect the net effect of the updated cost uplift and efficiency factors (i.e. change all prices by the same percentage). As a result, we expect the impact of the proposed 2024/25 NHSPS prices to be broadly similar with the impact of the 2023/24 NHSPS.

48. The 2023/24 findings presented include the following price affecting changes[7]:

    - Updating the market forces factor (MFF) values - Rather than moving to the fifth year of the previously published transition glidepath we propose

[7] For more information on our proposal to calculate 2023/24 prices, see section 10 of Part A of the consultation notice

to update the data used to calculate the MFF8. These new values utilise data from 2017-20 instead of 2014-17.

- Changes in the Clinical Negligence Scheme for Trusts (CNST) payments put through the NHSPS and allocated across clinical areas (HRG Subchapters).
- Adjusting prices for inflation and efficiency.
- Manual adjustments to the prices for cataract surgery, termination of pregnancy, and some high-cost drugs and devices.

49. We start this section by discussing the outputs of our base model run which simulates NHSPS priced revenues for providers and NHSPS priced expenditure for ICBs for 2022/23 and 2023/24, using 2018/19 HES activity data. We apply this constant level of activity to both years to isolate and better understand the impact of the proposed policy changes.

50. More details on how we propose to calculate 2023/24 prices are available in Annex DpD.

3.3 Anticipated aggregate impact of all 2023/24 proposals on providers

51. Figure 1 below shows the combined impact of our proposals for 2023/24 on NHSPS priced revenue for NHS and non-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 2023/24 using the proposed prices when compared to 2022/23 prices.

52. This scenario shows total NHSPS priced revenue for NHS providers increasing from £42.1 billion to £42.8 billion, an increase of +£0.7bn (+1.7%) in 2023/24 from 2022/23. The main driver of this change is the net effect of an uplift factor of +1.7% for inflation and efficiency.

53. The percentage increase in NHSPS priced revenue across NHS acute providers ranges from +1.0% to +1.9% (Figure 1).

[8] For more information on the MFF proposals, see section 10.4 of Part A of the consultation notice

Figure 1: Total 2023/24 NHSPS difference by
(a) NHS provider type

Provider Type	Total NHSPS Income (£'m) - 2022/23	Total NHSPS Income (£'m) - 2023/24	Total NHSPS Income Difference (£'m)	Percentage Difference (Total NHSPS Income)
Acute - Teaching	£19,515.89	£19,851.56	335.67	1.72%
Acute - Large	£9,939.61	£10,102.30	162.69	1.64%
Acute - Medium	£5,605.80	£5,697.23	91.43	1.63%
Acute - Small	£4,341.68	£4,422.42	80.74	1.86%
Acute - Specialist	£1,513.15	£1,537.17	24.02	1.59%
Acute - Multi-Service	£887.59	£896.64	9.05	1.02%
Non - Acute	£318.53	£322.77	4.24	1.33%
Total	**£42,122.25**	**£42,830.09**	**707.84**	**1.68%**

(b) NHS provider and independent providers

Provider Type	Total NHSPS Income (£'m) - 2022/23	Total NHSPS Income (£'m) - 2023/24	Total NHSPS Income Difference (£'m)	Percentage Difference (Total NHSPS Income)
NHS Providers	£42,122.25	£42,830.09	707.84	1.68%
Independent Providers	£1,593.34	£1,609.89	16.55	1.04%
Total	**£43,715.58**	**£44,439.98**	**724.40**	**1.66%**

54. For non-NHS providers, the expected NHSPS price revenue for 2023/24 is £1.6bn, an increase of £16.6m (1%).

55. The rest of this section focuses on NHS providers who are anticipated to make up £42.8bn of NHSPS priced revenue for 2023/24.

Figure 2: Total NHSPS price difference in 2023/24 by NHS provider type and point of delivery

(a) as a difference in £

Point of Delivery	Acute - Large	Acute - Medium	Acute - Multi-Service	Acute - Small	Acute - Specialist	Acute - Teaching	Non - Acute	**Total**
Non elective	62.36	33.76	3.72	30.79	5.55	125.46	1.96	**263.59**
Maternity	35.03	21.94	2.06	17.23	3.81	60.42		**140.49**
Outpatient Attendance	14.45	8.54	0.73	7.75	3.27	32.30	0.43	**67.48**
Elective	11.44	5.77	0.47	4.83	5.65	38.53	0.26	**66.95**
Daycase	14.99	7.48	0.64	7.45	2.40	32.60	0.17	**65.74**
Accident & Emergency	14.39	8.17	0.74	7.59	0.72	24.44	1.34	**57.39**
Outpatient Procedure	5.67	3.70	0.52	3.30	0.98	12.55	0.03	**26.75**
Unbundled	4.35	2.08	0.17	1.80	1.63	9.36	0.05	**19.45**
Total	**162.69**	**91.43**	**9.05**	**80.74**	**24.02**	**335.67**	**4.24**	**707.84**

(b) as percentage change

Point of Delivery	Acute - Large	Acute - Medium	Acute - Multi-Service	Acute - Small	Acute - Specialist	Acute - Teaching	Non - Acute	**Total**
Maternity	4.09%	4.12%	3.56%	4.30%	4.31%	4.24%		**4.18%**
Accident & Emergency	1.63%	1.61%	0.95%	1.84%	1.50%	1.77%	1.39%	**1.68%**
Outpatient Procedure	1.59%	1.56%	1.21%	1.84%	1.83%	1.62%	1.62%	**1.62%**
Non elective	1.54%	1.51%	0.98%	1.74%	1.94%	1.68%	1.46%	**1.62%**
Elective	1.19%	1.14%	0.62%	1.35%	1.44%	1.38%	0.90%	**1.31%**
Daycase	1.25%	1.14%	0.64%	1.42%	1.06%	1.40%	1.30%	**1.30%**
Unbundled	1.16%	1.11%	0.58%	1.38%	1.26%	1.24%	0.90%	**1.20%**
Outpatient Attendance	1.15%	1.15%	0.59%	1.36%	1.14%	1.25%	1.10%	**1.20%**
Total	**1.64%**	**1.63%**	**1.02%**	**1.86%**	**1.59%**	**1.72%**	**1.33%**	**1.68%**

56. Maternity is expected to see the highest percentage change in NHSPS priced revenue with an increase of 4.2%. This is due to the changes in CNST payments for obstetrics[9]. The remaining points of delivery are expected to see increases of between 1.2% to 1.7%.

[9] For more information on our approach to including CNST in the NHSPS, see section 2.3 of the Annex DpD

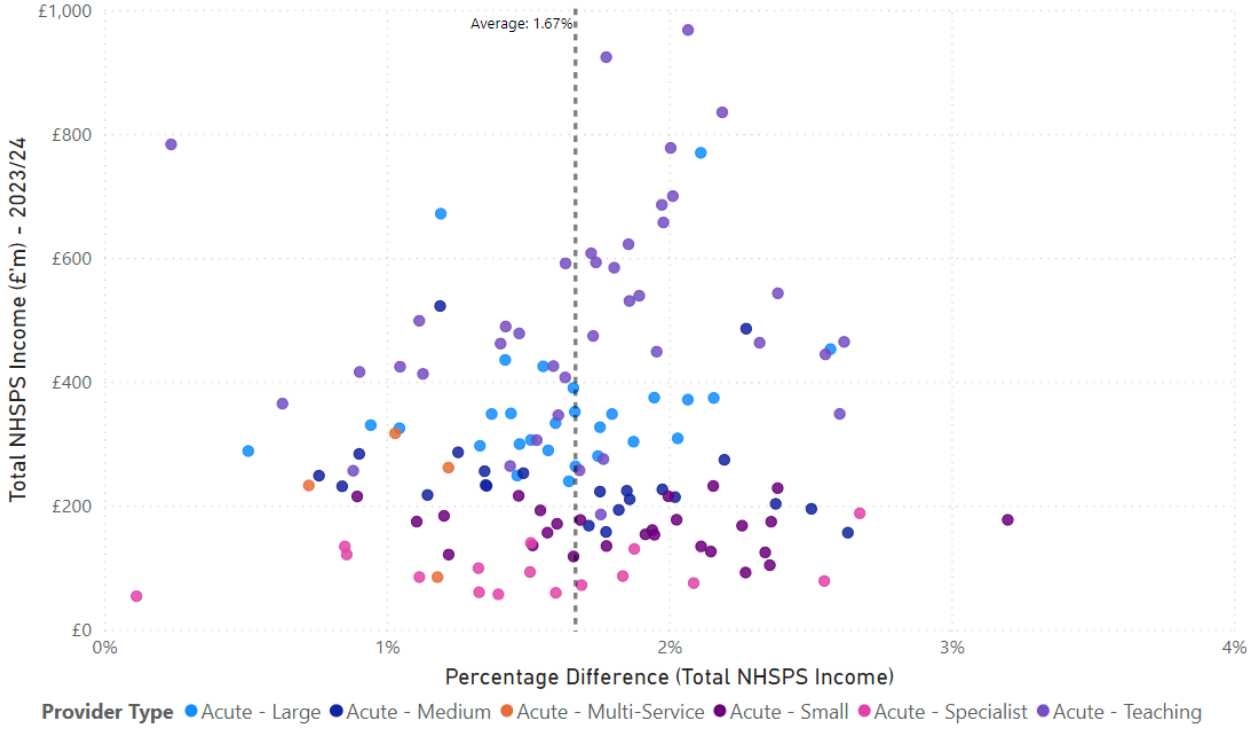
3.5 Anticipated aggregate impact of 2023/24 proposals by provider type

57. We expect that all acute providers will receive an increased income from our proposals in 2023/24. They represent the largest proportion of overall NHSPS priced revenue and therefore receive a greater share of the overall increase in NHSPS priced revenue resulting from the adjustment for cost uplift and efficiency. Figure 3 below shows that 73 out of 137 NHS providers will have an above average increase in NHSPS priced revenue.

Figure 3: Number of NHS providers, excluding non-acute, that are above or below the average change in NHSPS priced revenue in 2023/24

Provider Type	Above Average	Below Average	Number of providers
Acute - Large	13	15	28
Acute - Medium	13	10	23
Acute - Multi-Service		4	4
Acute - Small	18	9	27
Acute - Specialist	6	10	16
Acute - Teaching	23	16	39
Total	**73**	**64**	**137**

Figure 4: Overall impact of NHSPS proposals on % NHSPS price difference for NHS providers, excluding non-acute, in 2023/24



58. Figure 4 shows that all acute providers are anticipated to see an increase in the percentage of NHSPS priced income as a proportion of 2022/23 NHSPS priced income with an average increase of 1.7%, in line with the increase in cost uplift factor. Most acute providers are anticipated to see gains between 0.5-2.5%. The outlying gains for a number of providers can be attributed to changes in MFF payments, driven by a greater change in unavoidable costs relative to their 2022/23 values and/or the result of a merger/acquisition impacting on the revised MFF value, as well as changes in CNST payments particularly for maternity services.

3.7 Anticipated aggregate impact of all 2023/24 proposals by ICB

59. The expected impact of the 2023/25 NHSPS proposals on commissioner spending is presented in figures 5 and 6 below. Non-acute providers are included in the calculations to give the most comprehensive impact at ICB level. 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.

60. Overall NHSPS priced expenditure by ICB commissioners is expected to grow by approximately £0.6bn (1.7%).

Figure 5: Overall impact of NHSPS proposals on commissioner spending for local and central commissioners in 2023/24

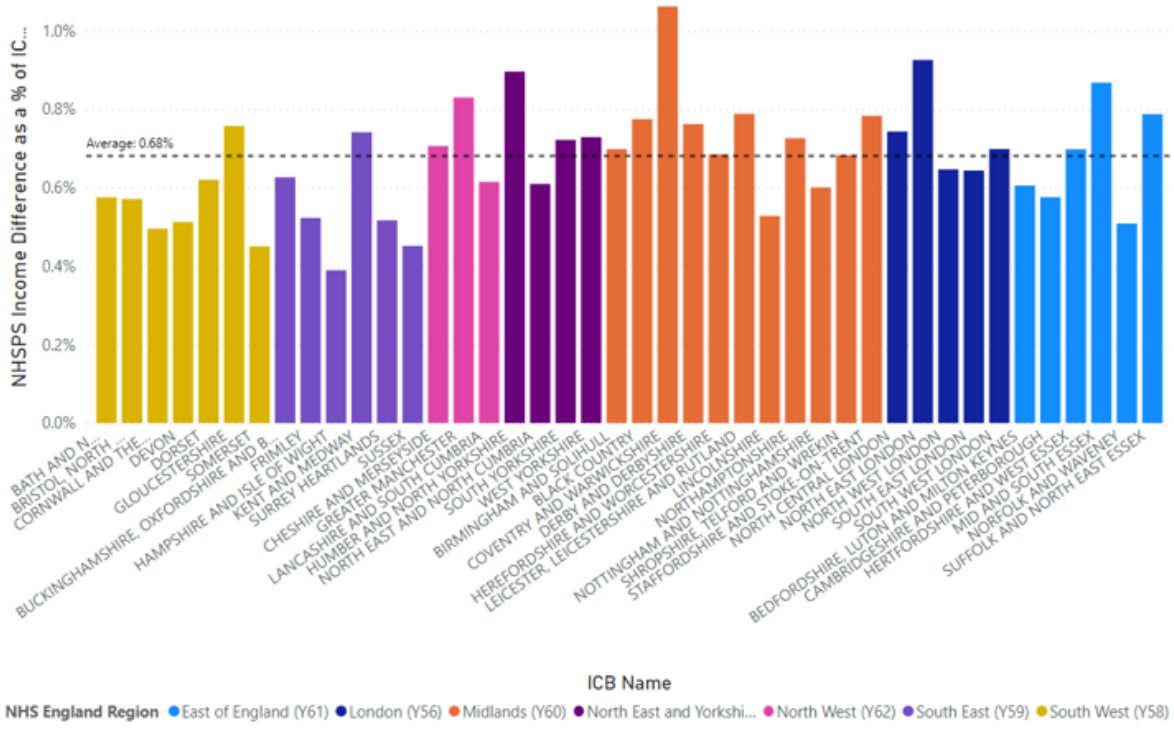
Commissioner Type	Total NHSPS Payment (£'m) - 2022/23	Total NHSPS Payment (£'m) - 2023/24	Total NHSPS Income Difference (£'m)	Percentage Difference (Total NHSPS Income)
ICBs	£38,531.48	£39,177.28	645.81	1.68%
NHS England Specialised Services	£3,506.60	£3,564.87	58.26	1.66%
NHS England Armed Forces and Prisoners	£60.67	£61.54	0.87	1.43%
Total	**£42,098.75**	**£42,803.69**	**704.94**	**1.67%**

61. Figure 6 shows the impact by ICB and region for expected ICB expenditure as a percentage of 2022/23 allocation. The impact in anticipated NHSPS priced expenditure is mainly driven by the net effect of an uplift for inflation and efficiency, as well as proposed changes to MFF.

62. The impact by ICB as a percentage of ICB allocations is expected to differ from that for providers because of services commissioned by ICBs from outside their ICB and providers also receiving income from outside their ICB.

63. Our analysis indicates that at an ICB level, aggregate NHSPS priced spending as a percentage of allocations is expected to increase by an average of 0.7%.

Figure 6: Change in NHSPS priced spending in 2023/24 as a percentage of ICB 2022/23 allocations by ICB



64. Figure 6 above also shows the aggregate impact of our proposals for 2023/24 on NHS providers by region. South West and South East regions sit marginally below the average percentage increase.

4 Impacts relating to equality

4.1 Overview

65. Under Section 149 of the Equality Act 2010 (Equality Act), NHS England has a duty, in exercising its functions, including that of pricing, 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.

66. 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.

67. 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

68. The NHSPS may impact people differently based on their characteristics if HRGs with different price uplifts are utilised disproportionality by people with a given characteristic, leading to an unequally distributed growth in funding for care. For the purposes of this impact assessment, we have considered the impact of our proposals on the nine protected characteristics listed above and also the Index of Multiple Deprivation (IMD) is used to consider inequality by deprivation[10].

69. Patient age, race, gender and IMD are recorded in the 2018/19 Hospital Episode Statistics (HES) data set and are independently quality assured by NHS Digital. The use of HES data therefore enables analysis of how the proposed 2023/25 NHSPS prices would affect spending on patients with different recorded age, race, gender and IMD, applying the same assumptions set out in Section 1 of this impact assessment. For some records in HES, these patient variables have not been recorded or have been excluded following quality assurance. In the figures below, uncategorised data is excluded. We have assessed growth in prices aggregated by these patient variables and individual ICB and clinical areas (as determined by subchapter categorisation).

70. 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.

71. Additionally, working in partnership with the NHS England Patient Equalities Team we have carefully considered whether it is possible to identify any potential positive or adverse equalities or health inequalities impacts of our proposals, and have prepared Equality and Health Inequalities Impact Assessment (EHIA) templates to document these considerations. Based on the available evidence no unmitigated concerns have been identified to date.

72. The consultation process offers the opportunity for providers, ICBs, and interested agencies, organisations and individuals to comment on our

assessment. Each policy and EHIA template will be reviewed as necessary post analysis of consultation feedback.

4.3 Assessment

4.3.1 Age

73. 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.

74. Figure 7 shows the anticipated change in spending for the different age groups, where the age field was populated in HES. Based on our assessment, we estimate the proposed NHSPS prices would increase spending for all age groups by between 1.4% to 2.5%. Age groups 20-29 and 30-39 have a marginally higher growth rate due to increased obstetric prices arising from CNST payments in this area. We therefore do not expect the 2023/25 NHSPS proposals to have a material disproportionate impact on patients based on age.

Figure 7: Anticipated changes in NHSPS priced income in 2023/24 by age group

Age_Band_10_YRS	Total NHSPS Income (£'m) - 2022/23	Total NHSPS Income (£'m) - 2023/24	Total NHSPS Income Difference (£'m)	Percentage Difference (Total NHSPS Income)
0-9	£2,706.13	£2,760.73	54.60	2.02%
10-19	£1,855.61	£1,887.82	32.22	1.74%
20-29	£3,560.89	£3,647.63	86.73	2.44%
30-39	£4,400.10	£4,510.55	110.45	2.51%
40-49	£3,398.17	£3,450.75	52.58	1.55%
50-59	£4,925.86	£4,995.18	69.33	1.41%
60-69	£5,933.39	£6,016.31	82.92	1.40%
70-79	£7,415.58	£7,518.57	102.99	1.39%
80-89	£5,851.05	£5,932.01	80.96	1.38%
90-99	£1,627.18	£1,649.70	22.53	1.38%
100 and above	£33.06	£33.51	0.45	1.37%
Total	**£41,707.02**	**£42,402.77**	**695.76**	**1.67%**

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

75. The NHSPS 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 NHSPS could have a disproportionate impact on different ethnic groups.

76. Based on our assessment, the proposed NHSPS prices would increase spending by between 1.6% and 2.1% for all ethnic groups, as illustrated in Figure 8 below.

77. We therefore do not expect the 2023/25 NHSPS proposals to have a material disproportionate impact on patients based on race, ethnicity or nationality.

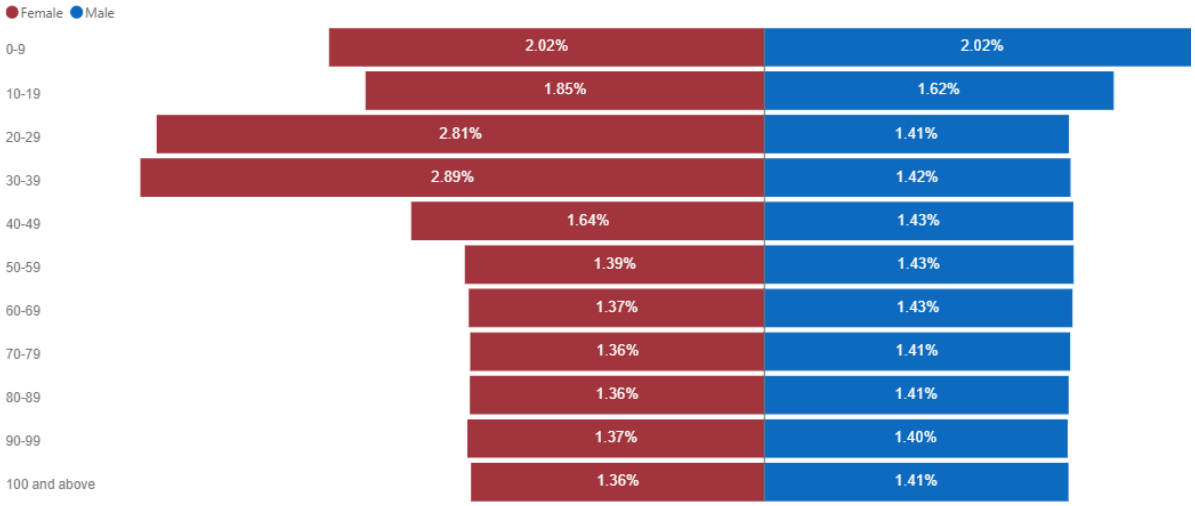
Figure 8: Anticipated changes in NHSPS priced payment in 2023/24, by ethnicity

Category	Total NHSPS Income (£'m) - 2022/23	Total NHSPS Income (£'m) - 2023/24	Total NHSPS Income Difference (£'m)	Percentage Difference (Total NHSPS Income)
Asian or Asian British	£2,321.73	£2,369.40	47.67	2.05%
Black or Black British	£1,233.92	£1,258.00	24.08	1.95%
Mixed	£433.46	£442.27	8.81	2.03%
Other ethnic groups	£4,491.64	£4,563.57	71.94	1.60%
White	£31,898.42	£32,421.97	523.55	1.64%
Total	**£40,379.16**	**£41,055.21**	**676.05**	**1.67%**

4.3.3 Gender

78. 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 NHSPS prices would increase spending by gender proportionately and slightly more for female patients (Figure 9). The slightly higher growth for female patients within the age bands 20-39 is due to obstetric price increases as a result of increased CNST contributions in this area. Overall, we therefore do not expect the 2023/25 NHSPS proposals to have a material disproportionate impact on men or women.

Figure 9: Anticipated changes in NHSPS priced payment in 2023/24, by gender.



Gender_Description	Total NHSPS Income (£'m) - 2022/23	Total NHSPS Income (£'m) - 2023/24	Total NHSPS Income Difference (£'m)	Percentage Difference (Total NHSPS Income)
Female	£23,281.69	£23,708.94	427.25	1.84%
Male	£18,784.08	£19,061.43	277.34	1.48%
Total	**£42,065.77**	**£42,770.36**	**704.59**	**1.67%**

4.3.4 Pregnancy and maternity

79. The 2023/25 NHSPS proposals would increase spending on maternity by 4.2% (£140 million) in 2023/24. The higher than average growth is the result of increased maternity CNST payments being applied to maternity NHSPS prices. This is in line with expectations and do not suggest that the 2023/25 NHSPS proposals would have a disproportionate impact on patients by pregnancy and maternity.

4.3.5 Sexual orientation

80. The NHSPS 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

2023/25 NHSPS proposals would have a disproportionate impact on patients by sexual orientation.

4.3.6 Marriage and civil partnership

81. The NHSPS 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 2023/25 NHSPS proposals would have a disproportionate impact on patients by marriage or civil partnership status.

4.3.7 Gender reassignment

82. Gender reassignment is a specialised service provided by the NHS. The NHSPS 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 2023/25 NHSPS proposals would have a disproportionate impact on this group of patients.

4.3.8 Disability

83. 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 2023/25 NHSPS proposals would have a disproportionate impact on this group of patients.

4.3.9 Religion or belief (including lack of belief)

84. The NHSPS 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 2023/25 NHSPS proposals would have a disproportionate impact on this group of patients.

4.3.10 Deprivation

85. Patient activity and associated payments have been grouped by geographic area to population quintiles representing comparative deprivation in that area. The anticipated NHSPS priced payment for the most deprived population quintile for 2023/24 is nearly £2 billion higher than the least deprived quintile (figure 10). This variation is proportional to higher levels of activity recorded for patients within the most deprived quintile.

86. There is very little difference in growth between 2022/23 and 2023/24 payments between quintiles of deprivation.

Figure 10: Anticipated changes in NHSPS priced payment in 2023/24, by deprivation quintile

IMD_Quintile_Description	Total NHSPS Income (£'m) - 2022/23	Total NHSPS Income (£'m) - 2023/24	Total NHSPS Income Difference (£'m)	Percentage Difference (Total NHSPS Income)
Least deprived 20%	£7,420.97	£7,535.90	114.93	1.55%
Less deprived 20-40%	£7,871.54	£7,998.31	126.78	1.61%
Mid-point deprivation 40-60%	£8,228.46	£8,362.88	134.42	1.63%
More deprived 20-40%	£8,536.54	£8,680.79	144.25	1.69%
Most deprived 20%	£9,143.20	£9,309.70	166.50	1.82%
Total	**£41,200.70**	**£41,887.58**	**686.88**	**1.67%**

4.3.11 Other considerations

87. While we do not anticipate the 2023/25 NHSPS proposals to have a disproportionate impact on patients with protected characteristics, we also expect providers and commissioners to take any necessary steps to ensure unintended consequences are mitigated and compliance with the equality duty when designing and/or commissioning services.

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