Annex A

2019/20 planning prices: an explanatory note

Produced by NHS England and NHS Improvement

Document Classification: Official

NHS England Publications Gateway number: 08660 (a)
1. To support planning for 2019/20, NHS England and NHS Improvement have published draft National Tariff Payment System (NTPS) prices.\(^1\) These planning prices are not final. The final proposed prices will be published as part of the statutory consultation on the 2019/20 NTPS in January 2019. We have tried to minimise any changes between the planning prices and those that will be subject to statutory consultation.

2. This note summarises the proposed changes in policy and method since the 2017/19 NTPS that are reflected in the planning prices.

3. All policy proposals for the 2019/20 NTPS will be subject to statutory consultation, starting in January 2019. The statutory consultation will give details of the feedback we have received through earlier engagement and will be accompanied by a detailed impact assessment of the final proposals.

4. We have produced individual impact analysis reports for commissioners and every provider that delivers nationally priced NHS services. These reports were initially produced alongside the October 2018 draft price relativities and shared with nominated contacts at each organisation through an online portal. They have been updated to reflect the planning prices and will again be available via the portal. Please contact pricing@improvement.nhs.uk if you have questions about the reports.

5. The 2019/20 engagement grouper should be used to group data and derive healthcare resource groups (HRGs), conduct what-if modelling and estimate reimbursement that would be received under the national tariff for the 2019/20 financial year.

6. Full details of all policy proposals, final proposed prices and impact assessment will be published as part of the statutory consultation in January 2019. Please contact pricing@improvement.nhs.uk for more details.

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\(^1\) Available to download from [https://improvement.nhs.uk/resources/developing-the-national-tariff/](https://improvement.nhs.uk/resources/developing-the-national-tariff/)
Adjustments to national prices

7. **Tables 1 and 2** detail proposed adjustments to the amount allocated to national prices, including the cost uplift and efficiency factors used. **Table 3** gives an overview of the value of additional proposed adjustments to national prices to reflect money to be moved from clinical commissioning group (CCG) allocations to funding for NHS England Specialised Commissioning and to be used to pay for services subject to local pricing.

**Table 1: Proposed adjustments to cost base (amount allocated to national prices)**

<table>
<thead>
<tr>
<th>Source</th>
<th>Proposed change</th>
<th>Tariff prices affected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Sustainability Fund (PSF)</td>
<td>£1 billion transferred from PSF into national prices for emergency care.</td>
<td>Non-elective prices, excluding excess bed days</td>
</tr>
<tr>
<td>Clinical Negligence Scheme for Trusts (CNST)</td>
<td>CNST adjustments are made by applying a forward-looking adjustment to the amount included in the current tariff. The figure included in the 2017/19 NTPS for 2018/19 overestimated the actual amount collected, and the 2019/20 level of contributions is lower than this. This means national tariff prices will reduce by about £330 million.</td>
<td>Mainly maternity, elective, non-elective prices, based on the contributions collected by NHS Resolution</td>
</tr>
<tr>
<td>Inflation</td>
<td>Cost uplift factor: +3.8% [See Table 2 for a breakdown of the elements used for this figure]</td>
<td>All national and local prices</td>
</tr>
<tr>
<td>Centralised procurement</td>
<td>Lowering the cost uplift factor to fund overhead costs of Supply Chain Coordination Limited (SCCL) and reflect the reduced costs for providers of purchasing products through SCCL. For acute prices, this adjustment is -0.36%.</td>
<td>All national prices (with smaller adjustments for locally priced non-acute services – see <a href="#">Locally determined prices</a> section)</td>
</tr>
<tr>
<td>CQUIN</td>
<td>+1.25% (half of CQUIN total) transferred into core prices (including locally agreed prices)</td>
<td>All national and local prices</td>
</tr>
<tr>
<td>Efficiency factor</td>
<td>-1.1%</td>
<td>All national and local prices</td>
</tr>
</tbody>
</table>

**Table 2: Elements of the cost uplift factor**

<table>
<thead>
<tr>
<th>Cost</th>
<th>Estimate</th>
<th>Cost weight</th>
<th>Weighted estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pay</td>
<td>5.0%*</td>
<td>66.9%</td>
<td>3.4%</td>
</tr>
<tr>
<td>Drugs</td>
<td>0.6%</td>
<td>3.7%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Cost</td>
<td>Estimate</td>
<td>Cost weight</td>
<td>Weighted estimate</td>
</tr>
<tr>
<td>----------</td>
<td>----------</td>
<td>-------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Capital</td>
<td>1.8%</td>
<td>6.9%</td>
<td>0.1%</td>
</tr>
<tr>
<td>CNST</td>
<td>-1.0%</td>
<td>2.5%</td>
<td>-0.0%</td>
</tr>
<tr>
<td>Other</td>
<td>1.8%</td>
<td>20.0%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Total</td>
<td>100.0%</td>
<td></td>
<td>3.8%²</td>
</tr>
</tbody>
</table>

Please note: pay includes the direct payment to account for 2018/19 Agenda for Change (AFC) pay pressure (1.6%), the cost weighted 2018/19 non-AFC pay pressure above what was set in the national tariff (0.3%) and the anticipated pressure for 2019/20 (3.1%)

### Table 3: Payment quantum proposed to be moved from national prices to NHS England Specialised Commissioning contracts

<table>
<thead>
<tr>
<th>Source</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antenatal maternity payment pathway – specialist fetal medicine</td>
<td>£19.3 million</td>
</tr>
<tr>
<td>Delivery maternity payment pathway – abnormally invasive placenta</td>
<td>£5.4 million</td>
</tr>
<tr>
<td>Other cancer multidisciplinary teams (MDTs)</td>
<td>£29.7 million</td>
</tr>
</tbody>
</table>

Blended payment for emergency care

8. We propose that a blended payment approach will be the default for emergency care services commissioned by a clinical commissioning group (CCG). This would apply where the expected value of emergency care for that CCG at that provider in 2019/20 is over £10 million.

9. A blended payment would comprise a fixed amount (linked to expected levels of activity) and a volume-related element that reflects actual levels of activity. It would cover A&E attendances, non-elective admissions (excluding maternity and transfers) and ambulatory/same day emergency care.

10. Providers and commissioners may agree to adopt or maintain their own payment models for acute emergency care, observing the local pricing rules and principles set out in the NTPS.

11. Blended payment would mean the marginal rate emergency tariff (MRET) and the 30-day readmission rule would be abolished as national rules.

12. See Appendix 1 for draft guidance on implementing the proposed blended payment approach.

² Figures do not sum due to rounding.
Market forces factor

13. We propose to update the method and data for calculating market forces factor (MFF) values.

14. The new values would be introduced over five years. *2019/20 planning prices workbook*\(^3\) lists the proposed MFF values.

15. Details of how the proposed MFF values were calculated, the models used and the research evidence that informed the proposed method changes are available on the [NHS Improvement website](https://improvement.nhs.uk/resources/developing-the-national-tariff/).

Maternity pathway

Moving to non-mandatory prices

16. For the 2019/20 NTPS, all maternity pathway prices will not be national prices and would therefore be non-mandatory (to be agreed as local prices).

17. This is because the Health and Social Care Act 2012 does not allow the national tariff to include prices for services commissioned using arrangements with the Secretary of State under Section 7A of the National Health Service Act 2006. These ‘Section 7A’ services include the screening and immunisation services received by women and their babies. Rather than separating these services from the current pathway prices, we propose to remove the services from national prices altogether.

18. We are considering how to address this issue in the longer term and in the meantime we strongly encourage providers and commissioners to continue to use these prices.

19. The non-mandatory maternity prices were calculated using the same methodology as 2019/20 national prices.

Payment levels for the birth episode

20. The 2019/20 planning prices list seven prices for the birth episode – six for births in a midwifery or obstetric unit and one for home births. The price for home births is based on the ‘without complications’ price in the 2017/19 NTPS, adjusted for 2019/20 in line with other tariff adjustments.

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\(^3\) Available to download from [https://improvement.nhs.uk/resources/developing-the-national-tariff/](https://improvement.nhs.uk/resources/developing-the-national-tariff/)
21. The birth payment covers costs of care until the woman and her well baby transfer to the community midwifery team. It is setting-neutral and does not change whether the birth takes place on a midwifery or obstetric unit.

22. A list mapping the HRGs to the payment levels is included in the 2019/20 planning prices workbook.

Other maternity changes

23. We propose updates to the postnatal complexity factors used to assign care episodes to the standard, intermediate or intensive postnatal pathways.

24. The factors we propose to add are:

<table>
<thead>
<tr>
<th>Intermediate</th>
<th>Intensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Aged less than 16</td>
<td>• BMI over 50</td>
</tr>
<tr>
<td>• Neurological disorders</td>
<td>• Fetal anomaly</td>
</tr>
<tr>
<td>• Systemic lupus erythematosus (SLE)</td>
<td>• Cystic fibrosis</td>
</tr>
<tr>
<td>• OASIS/PN bladder dysfunction</td>
<td>• Pulmonary hypertension</td>
</tr>
<tr>
<td>• Acute fatty liver of pregnancy (AFLP)</td>
<td>• Peripartum cardiomyopathy</td>
</tr>
<tr>
<td>• Postpartum psychosis (level 2/3 critical care)</td>
<td>• Transplants</td>
</tr>
<tr>
<td>• Post intensive care (ITU) admission</td>
<td></td>
</tr>
</tbody>
</table>

25. We have also added some outpatient prices to the schedule of non-mandatory antenatal prices.

26. As shown in Table 3, we propose to remove specialist fetal medicine and abnormally invasive placenta from the scope of the maternity pathway prices. Designated centres will be directly reimbursed by NHS England Specialised Commissioning.

Currency design

27. In addition to the matters outlined above, our proposals for the 2019/20 NTPS involve the following currency design changes:

- Continuing to use HRG4+ currency design, moving to the version used for 2016/17 reference costs.
- Changing the scope of currencies so that wheelchair and spinal cord injury services have national rather than non-mandatory currencies.
- Creating new non-mandatory prices to support non face-to-face and non consultant-led outpatient attendances where clinically appropriate.
• Lowering frontloading levels for ophthalmology (decrease from 30% to 20%); dermatology (decrease from 30% to 20%); urology (decrease from 30% to 20%); nephrology (decrease from 10% to 0%).

• Updating the high cost drugs and devices lists following sector feedback and advice from steering groups (see 2019/20 planning prices workbook for details of the proposed changes).

• Introducing best practice tariffs (BPTs) for spinal surgery and emergency laparotomy (see 2019/20 planning prices workbook for details).

• Updating existing BPTs to reflect new data availability or developments in clinical practice (see 2019/20 planning prices workbook for details of the proposed changes).

• Removing reference to reimbursement arrangements for the innovation and technology tariff (ITT), although prostatic urethral lift systems will continue to be recognised in HRG prices. The ITT has been superseded by NHS England’s innovation and technology payment (ITP) programme.

• Making a blended payment approach the default payment method for adult and older people’s mental health services.

Method for determining national prices

28. We have used the same method as in previous years as the starting point for the proposed cost base for 2019/20. This means it has initially been set equal to the revenue that would be received under 2018/19 national prices, recognising proposed changes in the scope of nationally priced services. Table 1 shows the proposed adjustments to the amount allocated to national prices.

29. We propose the following for determining national prices:

• Setting a tariff for one year.

• Using overall the same method as in previous national tariffs to calculate national prices, adopting 2016/17 reference costs. The calculation model has been rebuilt since the last tariff was calculated, focusing on processing efficiency rather than the underlying logical process behind the model. A few minor anomalies were observed and corrected.

• Although maternity services would no longer have national prices, we have calculated these prices using the same method as national prices.

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4 See Section 4.5 of the 2017/19 NTPS for details.
5 See Section 4.2 of the 2017/19 NTPS for details.
• Following broadly the same approach to manual adjustments used for previous tariffs, with some improvements to the process of making manual adjustments to price relativities generated by the model.
• Managing volatility of the impact on specific services with manual adjustments as informed by discussions with appropriate expert clinical working groups
• Phasing in MFF changes with a five-year transition for new MFF values.
• Moving to the second step of the transition path for those chapters considered to be most affected by the move to HRG4+.

National variations

30. As outlined above, our proposals for 2019/20 involve updating MFF values and removing the MRET and 30-day readmission national variations when we introduce blended payments for emergency care.

31. The planning prices reflect the proposal, for specialist top-ups, to continue to the transition path’s second step, following the move to prescribed specialised services (PSS) designation. The three services that would have reduced funding (orthopaedics, paediatrics and spinal surgery services) would receive 50% of the difference, compared with 75% in 2017/19. We also propose updating the calculation of the top-up payment rates to account for additional changes regarding the identification rules, hierarchy and provider eligibility lists. A list of the rates used is included in the 2019/20 planning prices workbook.

32. Following NHS England’s recent consultation on evidence-based interventions, we propose to create a national variation to stop reimbursing certain interventions (which do not have an approved individual funding request). This will support systems to improve clinical outcomes for their population by ensuring that patients only receive interventions for which there is an established, high-quality evidence base.

Locally determined and non-mandatory prices

33. As mentioned above, the centralised procurement adjustment would have a different impact for different services. This would be reflected in local pricing agreements by using the following adjustments:

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6 See Section 4.4 of the 2017/19 NTPS for details.
### Acute vs. MH vs. Ambulance vs. Community

<table>
<thead>
<tr>
<th></th>
<th>Acute</th>
<th>MH</th>
<th>Ambulance</th>
<th>Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change</td>
<td>-0.36%</td>
<td>-0.10%</td>
<td>-0.08%</td>
<td>-0.05%</td>
</tr>
</tbody>
</table>

34. In addition to the proposals for emergency care and maternity services, we propose to make the following changes to the local pricing rules for 2019/20:

- **Updating local pricing rule 5** (high cost drugs, devices and listed procedures) to allow the use of reference prices that are higher than the nominated supply cost of a drug. This would support appropriate incentives for providers to switch to the use of biosimilars such as adalimumab.

- **Updating local pricing rule 7** (adult and older people mental health) so that blended payment is the default approach for mental health services for working-age adults and older people. The blended payment for mental health would consist of a fixed element and a variable element based on a measure of activity (with mental health clusters being the default) and an element linked to locally agreed quality and outcomes measures. Providers and commissioners can also include a risk share agreement as part of a blended payment approach. Further guidance will be provided in the statutory consultation.

- We are not proposing any change to local pricing rule 10 (ambulance services). However, we do plan to amend the guidance on emergency ambulance services. This would reflect the recommendation in the recent report, *Operational productivity and performance in English NHS ambulance trusts: unwarranted variations*, to support the safe reduction in avoidable conveyance. Payment arrangements should reflect the additional time on scene and costs incurred by ambulance services when supporting patients to stay at home or be referred to alternative services. Commissioners should take into account the specific pay pressures facing ambulance providers as a result of their staffing mix (e.g., Agenda for Change bandings, unsocial hours) compared to other types of providers.

35. *2019/20 planning prices workbook* also contains proposed new non-mandatory prices for:

- advice and guidance services
- renal transplantation
- specialist rehabilitation
- wheelchair services
Appendix 1: Draft guidance on blended payments for emergency care

Please note: This guidance is draft and is intended to support the planning process.

We may update this guidance in light of our final proposal for blended payment for emergency care. The proposal will be subject to statutory consultation, starting in January 2019.

Rationale

As set out in Payment system reform proposals for 2019/20, we are proposing to introduce a blended payment system for emergency care services. We are proposing redesigning how the payment system works for emergency care to:

- support a more effective approach to resource and capacity planning that focuses commissioners and providers on making the most effective and efficient use of resources to improve quality of care and health outcomes
- provide shared incentives for commissioners and providers to work together to reduce avoidable non-elective admissions, reduce avoidable use of hospital A&E services, and ensure patients receive the right care in the right place at the right time – with providers and commissioners having shared financial responsibility for levels of hospital-based activity.
- fairly reflect the costs incurred by efficient providers in providing care and provide incentives for continuous improvements in efficiency
- minimise transactional burdens and friction and provide space to transform services.

Where local health systems have already moved – or in future agree to move – to a different payment system as part of a move away from an episodic based reimbursement system, they would be able to maintain or adopt this approach, as now, by publishing a local variation to the default payment approach published in the national tariff and through local prices.

What is a blended payment for emergency care?

A blended payment would comprise a fixed amount (linked to expected levels of activity) and a volume-related element that reflects actual levels of activity. The fixed payment would operate at an individual CCG-to-provider level.
Providers and commissioners should work together to agree realistic forecast levels of activity for emergency admissions, A&E attendances and ambulatory/same day emergency care for 2019/20. Agreed forecast activity should reflect the effects of demographic pressures as well as realistic assessment of the impact of system efforts to reduce demand. This forecast would then be used to calculate the fixed payment by applying the 2019/20 HRG prices for emergency activity (published as part of the NTPS) or local prices where appropriate.

Commissioners and providers should involve their sustainability and transformation partnership (STP) or integrated care system (ICS) and other local system partners in planning discussions and in agreeing levels of activity. Where discussions between provider, commissioner and STP/ICS do not lead to agreement, the national process for dispute resolution will apply. NHS England and NHS Improvement regional teams will look to resolve disagreements over forecast activity levels before areas enter arbitration via the national Independent Arbitration Panel. Further details will be contained in the 2019/20 dispute resolution policy, to be published early in 2019.

This total fixed payment for emergency care would be the baseline to which the variable payment would apply. Where actual priced activity (based on activity x HRG price or local price) is higher than the forecast level of priced activity which forms the fixed payment, the provider would receive 20% of the difference between the fully priced value (based on activity x HRG price or local price) of this activity and the agreed fixed amount. Where priced activity is below the forecast level of priced activity, the provider would retain 80% of the difference between the fixed payment and the fully priced value of this activity.

The contract value agreed via the blended payment approach will be reduced by the agreed 2017/18 value of both the MRET and 30-day readmission rules.

**Marginal rate emergency rule**

We are proposing to remove the marginal rate emergency rule (MRET) for the 2019/20 NTPS.

**Emergency readmissions within 30 days**

We are proposing to remove the 30-day readmission rule for the 2019/20 NTPS.

Currently, where money is retained from not paying for emergency readmissions, this should be re-invested by the commissioner in post-discharge services that support rehabilitation and reablement to prevent avoidable readmissions. Providers
and commissioners should discuss the effectiveness of any such investments in reducing readmissions and take this into account when agreeing the level of planned activity.

The financial impact on the removal of the 30-day readmissions rule will form part of the activity and financial baseline for the blended payment approach. Providers and commissioners should have due regard to the values in the recent joint data collection exercise combined with any subsequent actions when agreeing the appropriate volume and value of activity included in the blended payment baseline.

No adjustments would be made to commissioner allocations when removing this rule and it would be for local systems to ensure a cost neutral impact from the removal of the rule – either by agreeing that current reinvestments are successfully reducing emergency readmissions and should continue (resulting in a lower fixed payment), or by agreeing that ineffective investments are stopped subject to considering the value for money of stopping investments with other providers that would invoke penalty clauses.

Avoidable emergency readmissions remain an indicator of service quality. We would expect providers and commissioners to continue to monitor and review the number of avoidable emergency readmissions.

**Scope of activity in the blended payment**

The following activity which would be within the scope of blended payment is:

- all emergency admissions (admin method 21-25, 28, 2A-2D)
- emergency admission excess bed days
- A&E attendances at Type 1, 2 and 3 A&E facilities, including urgent treatment centres where they are classified as a type 3 A&E service
- all ambulatory/same day emergency care activity, even if this is currently being coded as something other than an emergency admission or A&E attendance
- activity that is not currently nationally priced but meets those criteria.

All other activity would be excluded, specifically:

- all other admission methods
• specialised commissioned services\(^7\), both elective and non-elective
• all unbundled elements, such as critical care spells associated with emergency admissions and high cost drugs and devices.

Locally priced services included in the blended payment would need local prices to be agreed as normal, with regard to the local pricing rules as set out in the NTPS.

Ambulatory/same day emergency care is included in the scope of the blended payment in order to incentivise use of same day emergency care where clinically appropriate to do so.

There is a variable picture for how ambulatory/same day emergency care services are currently being recorded and paid for. Approaches include:

• using national prices for zero-day length of stay emergency admissions (with any short stay adjustments and MRET applied)
• using national A&E prices
• agreeing local prices
• recording the activity as an outpatient attendance as part of a ‘hot’ clinic.

Inclusion within the blended payment should mean that payment for ambulatory/same day emergency care is more straightforward to implement than at present.

Providers and commissioners should agree how this activity is currently being recorded and how it will be recorded in future taking into account the counting and coding provisions as part of the Standard Contract. We would work with system partners to create a consistent approach to recording ambulatory/same day emergency care activity in future tariffs.

**Best practice tariffs**

Changing the default payment system for emergency care to a blended approach would mean changing the way certain best practice tariffs (BPTs) operate. We do not want to remove the financial incentive for providers to deliver best practice and so we are proposing to change the way BPTs are operationalised to fit into the blended payment system.

\(^7\) Services commissioned by NHS England Specialised Commissioning are excluded from blended payments as a default. However, we propose that MRET for these services would still be removed.
We propose to remove the same day emergency care BPT. This BPT over-reimburses certain activity which takes place on the same day rather than overnight. We would expect discussions between providers and commissioners to look at emergency activity as a whole and decide the best way to manage and treat patients where same day emergency care is part of the most appropriate emergency care pathway.

The following BPTs are either wholly or partially related to emergency care:

- Acute stroke care
- COPD
- Diabetic ketoacidosis and hypoglycaemia
- Fragility hip fracture
- Emergency laparotomy
- Heart failure
- Non-ST segment elevation myocardial infarction
- Paediatric Diabetes
- Pleural effusion
- Transient ischemic attack

We are proposing that commissioners and providers should agree a forecast level of performance against the criteria in these BPTs which would form part of the fixed element of the blended payment. We would continue to publish BPT prices to support calculation of the blended payment, and so they can be used for activity which is outside the scope of the blended payment.

Local areas could agree, if they wish, to pay on the basis of actual performance by incorporating differences from plan into the variable payment. We would not mandate this approach but areas that wish to review and pay on actual BPT performance on either a three- or six-month basis would be able to do so. We would expect that performance against BPTs should still be monitored quarterly from a quality perspective.

**Threshold**

We propose to set a threshold of £10 million (based on the expected value of emergency activity at the provider for the CCG at the start of the year). Where expected activity is valued at less than £10 million for 2019/20, the provider and
CCG would continue to transact on the basis of the published national HRG prices for all emergency activity.

The £10 million amount would include all elements of the blended payment (see Scope of activity in the blended payment above) as well as MFF adjustments and expected BPT attainment rates.

Providers and commissioners could also consider agreeing a ‘collar’ around the expected level of activity where small variances would not result in any change to the Expected Contract Value. This may help to reduce administrative burden by avoiding the need to make adjustments for small variances on expected levels of activity. It could also be used to manage any small differences in forecast levels of activity between provider and commissioner. The inclusion of a collar is not being mandated nationally as part of the blended payment, but could be agreed via a local variation.

**Break glass**

In *Payment system reform proposals for 2019/20*, we proposed that contracts would include a ‘break glass’ clause which applies when activity is significantly higher or lower than assumed and requires the emergency care payment elements of the contract to be reviewed and potentially renegotiated.

We have analysed previous plan data alongside outturn activity levels and found there is a high level of variation between plan and outturn levels at organisation level. Some of this is likely due to known changes in treatment pathways and coding and some may be due to variability in plan estimates. This makes it difficult to set a break glass clause based on nationally available data.

We are therefore proposing that a break glass clause, and the level of actual priced activity at which a break glass clause is activated, are agreed locally and set out in each contract. If areas agree that a break glass clause is not needed as part of their contract agreement, then this should be specified.

The break glass arrangements would have two components:

- a trigger point (%) where actual priced activity is above or below the planned level
- a set of binding arrangements which will apply in the event the trigger point is reached.
These arrangements are to be agreed and included in the contract at the point of signature.

As with agreement on the level of activity, if the parties can’t agree on these components, NHS England and NHS Improvement regional teams will look to resolve disagreements.

The NHS Standard Contract team will provide model contract wording which providers and commissioners may use to describe the break glass arrangements. This would be published alongside the statutory consultation on the 2019/20 NTPS in January 2019.

**Duration of blended payment**

We propose that the 2019/20 NTPS will be valid for one year, from April 2019. We would expect that the blended payment would be updated for each tariff cycle, including agreeing levels of emergency activity to inform the fixed element of the blended payment. This would ensure that any under- or over-estimate of activity in any one tariff cycle is not hard-wired into contracts in future.