2019/20 National Tariff Payment System – A consultation notice

A joint publication by NHS England and NHS Improvement

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All documents relating to the statutory consultation on the proposed 2019/20 National Tariff Payment System are available to download from: https://improvement.nhs.uk/resources/national-tariff-1920-consultation/

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**Please note:**

**Part A** of this document is the statutory consultation notice. It starts on page 5.

**Part B** of this document is the proposed 2019/20 National Tariff Payment System. This is shown as it would appear in final form. It starts on page 100.

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1. **About this document**

1. This is the statutory consultation notice for the 2019/20 National Tariff Payment System (NTPS).

2. The document is in two parts:

   * Part A – policy proposals. This contains:
     - an introduction that sets the context for the 2019/20 NTPS and explains how you can respond to this consultation notice
     - a summary of how we have engaged with stakeholders in developing the proposals in this notice
     - an explanation of what we propose to change from the 2017/19 NTPS.
   * Part B – draft tariff. This contains a draft of the proposed 2019/20 NTPS, shown as it would appear in final form. This includes sections on:
     - the scope of the tariff
     - the currencies that are the building blocks for national prices and some local prices
     - the method for determining national prices
     - national variations to national prices
     - locally determined prices
     - rules for emergency care services
     - payment rules.

3. This document should be read in conjunction with the annexes (which, unless otherwise stated, form part of the NTPS) and the supporting documents.

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2. Context

4. The 2017/19 NTPS was the first multi-year tariff and introduced some significant changes, in particular moving to Healthcare Resource Group 4+ (HRG4+) currency design.

5. For 2019/20, NHS England and NHS Improvement\(^1\) are again proposing some significant changes to further develop the payment system to support ongoing developments in the health and care sector, including those set out in the NHS Long Term Plan.

6. Our principal proposed changes are to:

   • set the tariff for one year, rather than two
   • use nationally set rules and prices to make a ‘blended payment’ the default payment approach for emergency care, supported by a £1 billion transfer from the Provider Sustainability Fund (PSF) into emergency care prices
   • update the calculation method and underlying data for the market forces factor (MFF), introducing the new values over a five-year period
   • remove around £204 million from the amount covered by the national tariff to reflect changes to arrangements for procurement of products for the NHS
   • make all maternity prices non-mandatory, to address a specific issue relating to pricing of public health services.

7. We want our proposals to support more effective 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. We believe commissioners and providers should have shared incentives and financial responsibility to provide the right care in the right place at the right time.

8. In many health economies, providers and commissioners are already working together, using the flexibilities allowed by the NTPS,\(^2\) to develop and implement payment approaches that best suit their local situation. Our proposals for the 2019/20 NTPS should not stand in the way of local systems continuing to move

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\(^1\) In this context, ‘NHS Improvement’ refers to Monitor, the body on which statutory national tariff functions are conferred by the Health and Social Care Act 2012 (the 2012 Act).
\(^2\) See Section 6 of the 2017/19 NTPS.
faster towards other payment approaches, such as population-orientated payment models, where appropriate.

9. We also propose to introduce a number of new non-mandatory prices, either to test prices as part of the development of potential national prices, or to offer a benchmark to be used a starting point for local price-setting discussions.

10. The new benchmark prices we are proposing are for advice and guidance, IVF services, specialist rehabilitation and tobacco dependency services for inpatients and pregnant women.

11. The supporting document, *Non-mandatory currencies and prices*, gives details of the prices, how they have been calculated and whether they are intended as benchmark prices.
3. **Responding to this consultation**

3.1. **Statutory consultation on the national tariff and the objection process**

12. The proposals for the 2019/20 NTPS are subject to a statutory consultation process as required by the Health and Social Care Act 2012 (the 2012 Act). This provides an opportunity for stakeholders to tell us what they think about the proposals. It also provides an opportunity for clinical commissioning groups (CCGs) and ‘relevant providers’ (see below) to object to the method we have proposed for determining national prices. **The consultation period ends at midnight at the end of 21 February 2019.**

13. You can find further information on the statutory consultation, objection process and relevant legislation in Annex PpB.

3.1.1. **Whose objections are relevant for the statutory objection process?**

14. The 2012 Act provides a statutory process for challenging the proposed method for determining national prices. If a sufficient number of objections to the proposed method are received from either CCGs or ‘relevant providers’, NHS Improvement may not proceed with the tariff without a reference to the Competition and Markets Authority (CMA) or further statutory consultation.

15. There are two categories of relevant provider:

   a. Licence holders. This refers to providers holding an NHS Improvement licence, including NHS foundation trusts and independent providers.

   b. Other relevant providers as defined in the National Health Service (Licensing and Pricing) Regulations 2013. The regulations state that an individual or body is a relevant provider if they do not hold a licence but provide an NHS service for which there is a national price proposed in this consultation notice. This refers to current providers of the service.

16. The definition of relevant provider includes all NHS trusts that provide nationally priced services.

17. The only commissioners whose objections to the method are relevant for the statutory objections process are CCGs: NHS England, in its role as a commissioner of specialised services, is not included in this definition.
3.1.2. Objections to the method

18. While we welcome comments on all our proposals, the 2012 Act makes it clear that the statutory objection process applies only to objections to the “method or methods it [NHS Improvement] proposes to use for determining the national prices” of NHS healthcare services.\(^3\)

19. The method includes the data, method and calculations used to arrive at the proposed set of national prices and prices for emergency care services, including the cost adjustments as set out in Sections 8 and 11.6 to 11.8. It does not include the prices themselves.

20. The proposed method does not include:

- the proposed national currencies
- the proposed national variations, such as the market forces factor and top-ups for specialised services
- the rules for agreement of local variations
- the methods for approving or determining local modifications
- the rules for determining local prices
- the rules for emergency care.

3.2. Consequences of objections

21. The objection thresholds are:

- 66% or more of commissioners (measured by number)
- 66% or more of relevant providers (measured by number).

22. If either objection threshold is met, NHS Improvement cannot publish the 2019/20 NTPS unless it undertakes a further statutory consultation or makes a reference to the CMA.

23. If NHS Improvement were to reconsult on revised proposals, we would publish another consultation notice and the process would begin again. If NHS Improvement were to refer to the CMA, objecting parties would have the opportunity to set out details of their objection.

\(^3\) Health and Social Care Act 2012, Sections 118(3)(b) and 120(1)
24. In either case, the 2019/20 NTPS would be delayed. If the 2019/20 NTPS were delayed beyond 1 April 2019, the 2017/19 NTPS would remain in effect until a new tariff was published. If this were to happen, we would issue further guidance on interim arrangements.

3.3. Other responses to the consultation

25. In addition to consulting on the method for setting national prices, we are asking for feedback on the entire package of proposals in the consultation notice. We welcome comments on any of these proposals and will consider your responses before making a final decision on the content of the 2019/20 NTPS.

26. Please submit your feedback through the online survey.  

27. The deadline for submitting responses is midnight at the end of 21 February 2019.

28. Please contact pricing@improvement.nhs.uk if you have any questions.

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4 https://engage.improvement.nhs.uk/pricing-and-costing/1920-tariff-consultation

11 2019/20 National Tariff Payment System – A consultation notice > Responding to this consultation
4. How we worked with stakeholders to develop our proposals

29. We have engaged with providers, commissioners, representative bodies and other appropriate stakeholders throughout the development of our proposals for the 2019/20 NTPS.

4.1. Engagement overview

30. Our engagement included:

- discussing proposals with providers, commissioners, Royal Colleges and other representative bodies
- taking part in external events relevant to tariff policy development
- holding regular meetings with our tariff advisory group, comprising members from providers, commissioners and representative bodies, to discuss policies as they were developed
- holding webinars to discuss specific policy proposals
- running an enhanced impact assessment (EIA) process, asking specific providers and commissioners to model the impact of our proposals using local data and comparing the findings with our assessment
- conducting a series of workshops across England to get feedback on initial policy proposals in June and July 2018
- publishing details of our principal proposed changes, draft price relativities and an accompanying survey to gather feedback in October 2018. We also created organisation-level impact analysis reports that showed the impact of the proposed policy changes on individual providers and commissioners.

31. Annex PpA provides details of the feedback we received on our initial policy proposals.

4.2. Expert review of draft price relativities

32. For the 2019/20 NTPS, we used the clinical expertise of the National Casemix Office’s expert working groups (EWGs). The EWGs are responsible for advising on the design of the casemix classifications known as healthcare resource groups (HRGs). The EWGs consist of clinicians nominated by their professional bodies and Royal Colleges. Each EWG focuses on a particular group of services, known in HRG design as a ‘chapter’ (for example, Chapter A covers services relating to disorders of the nervous system).
33. We initially discussed currency design and development with the EWGs. When we had an initial set of draft price relativities, we attended 18 EWG chapter meetings to discuss the prices and identify any illogical price relativities. We also received feedback from a further three EWGs which provided comments via correspondence.

34. After responding to EWG feedback on initial draft price relativities, we shared a revised set of draft prices to further check for illogical price relativities or any other potential issues. EWG feedback was then taken into account for the final price proposals.

35. More details of the manual adjustment process, the outputs and how we incorporate this into prices can be found in Section 11.5.

4.3. Enhanced impact assessment

36. In the development of the previous two tariffs (2016/17 and 2017/19) we ran an enhanced impact assessment process (EIA). This involved sharing draft prices with a group of providers and commissioners and asking them to model the impact using their data.

37. The process helped us to understand the differences between NHS Improvement’s impact assessment and assessments of likely impact made by individual providers. This enabled us to identify how we can resolve such issues to make future impact assessments more robust.

38. We again ran an EIA process for the 2019/20 NTPS. Details of the EIA findings are included in the main impact assessment report.

4.4. Workshops on initial policy proposals

39. During June and July 2018, we held 26 workshops across England to discuss our initial policy proposals, including four sessions specifically focused on mental health. More than 400 people took part. Annex PpA contains a summary of the feedback we received at the workshops.

4.5. Engagement on principal proposed changes

40. In October 2018, we published a short document setting out our principal proposed changes to the 2017/19 NTPS. This was accompanied by more detailed explanation of the proposed changes to the market forces factor.
(MFF), draft price relativities and surveys to gather feedback on the changes presented, and a separate survey to get more detailed feedback on the MFF proposals.

41. We received 333 responses to the overall survey and 79 to the MFF survey. We received feedback on the draft price relativities as well as letters from stakeholders raising specific concerns.

42. Of the 333 responses to the overall survey, the majority were from acute providers (120) and clinical commissioning groups (CCGs) (70). Thirteen of the responses came from organisations representing multiple CCGs.

43. We considered all feedback carefully. In this document we summarise the key findings from the survey on each of the proposals, and how we have responded to the feedback we received.

44. Annex PpA contains details of the feedback.

4.6. Further engagement on specific policy areas

4.6.1. Blended payment for emergency care

45. We carried out extensive engagement activities as we developed our blended payment proposals. This included attending multiple events with providers and commissioners, holding a webinar to set out the initial proposals and gather views, organising workshops to discuss design options with stakeholders and meetings with interested parties such as the Royal College of Emergency Medicine.

4.6.2. Market forces factor

46. Our proposals on the market forces factor have generated considerable interest and discussion. We ran a webinar on proposals and published detailed supporting information as part of the October engagement. We have also engaged extensively with London provider and commissioner representatives, who had raised significant concerns about the proposed changes, in the process of deciding how to implement the proposed policy.

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6  www.workcast.com/?cpak=3655757933401989&pak=4438590455127521
4.6.3. Maternity

47. During 2018 we attended events with every strategic clinical network in England and presented the planned changes to the maternity pathway. In addition, we have met individual Local Maternity Systems to discuss our proposals. We held a webinar in October 2018 to explain and gather views on potential changes to the maternity pathway.\(^7\)

4.6.4. Mental health

48. We have continued to engage with the sector to develop the payment system for mental healthcare. This included gathering feedback on the payment approaches we introduced in 2017/19, holding a series of workshops to discuss planned developments and seeking views on specific topics.

4.7. Conclusion

49. Our engagement activities have yielded a large amount of information and helped to improve the proposals contained in this statutory consultation.

50. Thank you to everyone who has given their time to work with us. This feedback has allowed us to continue to develop and improve these policies for implementation.

\(^7\) www.workcast.com/ControlUsher.aspx?cpak=3479465537906345&pak=9119643573446313
5. Setting a one-year tariff

Proposal

We propose to set the tariff for one year.

5.1.1. About this proposal

51. The 2017/19 NTPS was the first multi-year tariff. We decided to set a longer-term tariff following an analysis of the benefits and risks of setting different lengths of tariff. We felt that the advantages of predictability and stability for commissioners and providers outweighed the risks associated with locking down prices for such a long period. While certain risks highlighted by the sector during engagement on proposals for 2017/19 were realised, the move has generally been welcomed, particularly where it has reduced the in-year administrative burden and allowed the sector to focus more on service change rather than contract negotiation.

52. In setting a duration for the tariff for the next period, we have made a similar assessment based on our previous analysis of the benefits and risks of setting different lengths of tariffs.

53. We propose to set a tariff for one year.

5.1.2. Why we think this is the right thing to do

54. Our proposal takes into account the feedback from the sector, the policies we propose to include in the next national tariff and the wider context facing the NHS.

55. Over the coming year, the situation is very different to that in 2017/19. The NHS Long Term Plan sets a direction of travel that the national tariff must respond to and support. In addition, the introduction of a blended payment for emergency care is a new policy with a broad impact that is likely to require further refinement in future tariffs. As such, flexibility in tariff setting is likely to be of particular importance for 2019/20.

56. In our engagement with the sector on tariff policies, both during the summer workshops and in our October 2018 publication, Payment system reform

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proposals for 2019/20, we proposed setting a one-year tariff. The feedback we received strongly supported this proposal, based on the risks and uncertainties currently facing the sector. However, many respondents felt that setting longer tariffs was a positive move and that we should revisit this policy for subsequent tariffs.

Support for the proposal to set a one-year tariff

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<th>Neither support or oppose</th>
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6. Blended payment for emergency care

Proposal

We propose to use nationally set rules and prices to make a ‘blended payment’ approach the national default reimbursement model for emergency care activity.

The proposed change would go alongside the transfer of £1 billion from the Provider Sustainability Fund to acute emergency care prices.

We also propose abolishing the marginal rate emergency tariff (MRET) and 30-day readmission national variations.

6.1.1. About this proposal

57. We propose to use nationally set rules and prices to make a blended payment the default payment approach for emergency care services. This would cover non-elective admissions, accident and emergency (A&E) attendances and same day/ambulatory emergency care.

58. The blended payment model would be introduced by removing the relevant services from the scope of national prices and providing new pricing rules governing how the payment for these services would be determined locally. This would be presented in a new section of the NTPS document (see Section 7 in the draft 2019/20 NTPS included in this document).

59. The blended payment approach would involve:

- a fixed payment, constructed out of nationally set HRG prices and locally agreed activity levels
- payments or deductions, made at 20% of the relevant HRG price, for activity above or below this agreed level.

60. To the extent that activity exceeds or falls short of the agreed level, the adjusted payments would essentially create a risk share arrangement for providers and commissioners, providing shared incentives to manage controllable demand.

61. The proposed change would go alongside a proposed transfer of £1 billion from the Provider Sustainability Fund (PSF) to acute emergency care prices.
62. The marginal rate emergency tariff (MRET) and 30-day readmission rule would be removed from the NTPS and, as outlined in the *NHS Operational Planning and Contracting Guidance 2019/20*, the impact would be neutralised for both providers and commissioners.

63. The contract value agreed via the blended payment approach would be reduced by the agreed 2017/18 value of both the MRET and 30-day readmission rules. Providers would be eligible to receive additional central income equal to the MRET value confirmed by providers and commissioners as part of the Autumn 2018 exercise. Control totals will be set on the basis that for every £1 in MRET funding, the provider must improve its bottom-line position by £1. MRET funding will be paid quarterly in advance subject to providers agreeing their control total.

64. The financial impact on the removal of the 30-day readmissions rule would 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 Autumn 2018 exercise combined with any subsequent actions when agreeing the appropriate volume and value of activity included in the blended payment baseline.

65. The short stay emergency adjustment (SSEM) would apply to the emergency care prices set out in Annex DtA.

66. Local areas would be required to agree a ‘break glass’ level above and below the agreed activity level, at which point contractually agreed new reimbursement arrangements would apply. They would also have the flexibility to agree tolerance levels around the agreed activity level, within which the overall payment would not be varied. However, this is not being mandated.

67. We propose that the blended payment approach is the default for contracts where the expected value of the agreed level of emergency activity would be £10 million or more for 2019/20. For cases where the expected activity under the contract is below this value, payment would continue to be made on an episodic basis, payment would continue to be made on an episodic basis, using the emergency care prices set out in Annex DtA.

68. Local areas would be able to maintain different payment models that they have already agreed, or agree new alternative approaches, using provision in the
tariff rules for local departure from the default approach, as set out in the local pricing rules (see Section 6 of the draft 2019/20 NTPS).

69. We propose that best practice tariffs (BPTs) could continue to be used to incentivise specific clinical behaviour within the blended payment approach. However, we propose removing the same day emergency care BPT as the blended payment will incentivise shifts of activity to same day care where clinically appropriate.

70. The supporting document *Guidance on blended payment for emergency care* gives more details on the proposed approach.

6.1.2. Why we think this is the right thing to do

71. The key aim of the blended payment approach is to focus the efforts of providers, commissioners and local health systems on agreeing how best to use available resources to provide high-quality, responsive services for patients in the most cost-efficient way. This is consistent with the ambitions set out in the *NHS Long Term Plan* which highlighted the potential introduction of blended payment for emergency care.

72. As set out in our October 2018 publication, *Payment system reform proposals for 2019/20*, we believe that blended payments would:

- 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 reduce avoidable A&E attendances and non-elective admissions by providing the right 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 hospitals in providing care and provide incentives for continuous improvements in efficiency
- minimise transactional burdens and provide space to transform services.

73. In the survey, the proposal was generally supported.
Support for the proposal to introduce blended payment for emergency care

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<th>Strongly support</th>
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74. While the survey asked for feedback on two potential designs of the blended payment, the priority from comments was for a simple and easily implementable model – common concerns about the proposed blended payment as a whole included complexity and lack of local flexibility. Another concern was the risk that commissioners and providers would be unable to agree the elements of the blended payment.

75. There was mixed feedback on issues such as potential ‘break glass’ thresholds and ‘collar’ arrangements. Some saw the benefits, but others thought that they would just add further complexity. Other comments highlighted the importance of national guidance and defaults in the case of disagreements.

76. There was widespread support for the inclusion of ambulatory/same day emergency care within the blended payment proposals, although respondents felt that the lack of an agreed national definition, currency and price might hinder this. Many felt that strong guidance regarding coding of this activity would be required. We will work with system partners to create a consistent approach to recording ambulatory/same day emergency care in future tariffs.

77. There was general support for the proposed £10 million threshold. We had examined activity at provider/CCG level and found that around 90% of the value of CCG commissioned emergency care spend would be within scope of blended payments if a £10m threshold was used. Reducing this to £5m did not increase the coverage significantly, but did bring more smaller value contracts into scope.

78. There was broad support for national guidance to support commissioners and providers to agree activity levels, with a national default in cases where local areas were unable to agree.
79. Our policy proposals for blended payments for emergency care have taken this feedback into account. This includes our proposals to involve sustainability and transformation partnerships (STPs) and integrated care systems (ICSs) in helping commissioners and providers agree levels of activity (and/or break glass arrangements) and providing for support and, if necessary, mediation, from NHS England and NHS Improvement regional teams if providers and commissioners are unable to agree.

80. The Guidance on blended payment for emergency care supporting document provides more details on the proposed blended payment approach and how it could be implemented.
7. Market forces factor

Proposal

We propose to update the data used to calculate the market forces factor (MFF) to the most recent available at time of calculation. We also propose to update the method used to calculate the MFF.

7.1.1. About this proposal

81. The market forces factor (MFF) is a measure of unavoidable cost differences between healthcare providers, driven by the varying costs of land, labour and capital across the country. These costs are unavoidable and therefore a variable national price is needed to fairly compensate providers across the country. Each NHS provider is assigned an individual MFF value, which is used to adjust the national prices they are paid and commissioner allocations.

82. The MFF has been used in each national tariff and in the previous Payment by Results system. However, data and method for calculating the MFF have not been reviewed for almost 10 years.

83. The current MFF contains the following components:

Table 2: Current MFF components

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<th>Component (weight*)</th>
<th>Method and rationale for inclusion</th>
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<tbody>
<tr>
<td>Non-medical-and-dental (non-M&amp;D) staff (54.9%)</td>
<td>The local rate of pay in the broader labour market is used to take account of variations in both direct and indirect employment costs that are not fully addressed by national pay scales and regional pay allowances. Indirect employment costs include, for example higher turnover and vacancy rates. The going rate of pay in the private sector is estimated for each primary care trust (PCT) area(^9) using statistical modelling to remove the effect of differences in industrial structure, occupations and demographics between PCT areas. The values for each PCT area are smoothed to reduce large differences in MFF values between neighbouring PCT areas. Each trust site value is determined by the PCT area where it is located. The sites are then aggregated up to trust level using bed numbers.</td>
</tr>
</tbody>
</table>

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\(^9\) Primary care trusts were abolished in 2013. The current MFF is therefore based on PCT areas as they stood at the date of abolition.
### Component (weight*)

<table>
<thead>
<tr>
<th>Component</th>
<th>Method and rationale for inclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and dental (M&amp;D) staff (13.9%)</td>
<td>Accounts for the nationally set allowance that M&amp;D staff receive if they work in London.</td>
</tr>
<tr>
<td>Buildings (2.7%)</td>
<td>Building assets have different values between providers and therefore incur different capital charges and depreciation. The index is based on data on construction costs by PCT provided by the Royal Institution of Chartered Surveyors. The trust site index is determined by the PCT where it is located. The sites are then aggregated up to trust level using bed numbers.</td>
</tr>
<tr>
<td>Land (0.4%)</td>
<td>Reflects differences in providers’ financing costs due to differences in land values per hectare. Calculated for each trust by taking the net book value and dividing by the land area. London trusts with a significant non-London site have a land index for each site weighted together in proportion to the share of available beds at each site.</td>
</tr>
<tr>
<td>Other (28.1%)</td>
<td>Allows for costs (eg equipment, consumables) that do not vary materially and unavoidably between providers.</td>
</tr>
</tbody>
</table>

* The components are combined to give a single MFF value for each provider using the same national weights, based on the national proportions of expenditure on each component reported in NHS accounts.

84. We propose to update the MFF set out in Table 2 to incorporate more up-to-date data and to improve the accuracy of our representation of cost differences between providers.

85. The proposed methodology changes are:

- using travel to work areas (TTWAs)\(^{10}\) for the non-M&D staff index (rather than PCT areas)
- including business rates in the MFF
- basing the normalisation of each of the MFF components on operating revenue
- simplifying the smoothing methodology that reduces ‘cliff edges’ in MFF values between providers located close to each other

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\(^{10}\) TTWAs are estimates of geographical boundaries of local labour markets, produced by the Office for National Statistics. [www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/articles/traveltoworkareaanalysisingreatbritain/2016](http://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/articles/traveltoworkareaanalysisingreatbritain/2016)
• adding an allowance for providers on the fringe of London in the M&D staff index, in addition to the allowance already made for inner/outer London
• phasing the new MFF values in over five years in equal steps.

86. Following feedback on our initial MFF proposals, we have changed the proposed transition period from four to five years. This should allow systems more time to adjust to the proposed changes.

87. We have also updated the supporting document, A guide to the market forces factor, to provide more information on the proposed MFF. Annex DtF includes the models used to calculate the proposed MFF and an MFF ‘metrics engine’, which shows the impact of each step.

7.1.2. Why we think this is the right thing to do

88. The data and method for calculating the MFF have not been reviewed or updated for almost 10 years and do not therefore reflect up-to-date information on variation in costs around the country. In addition, the current methodology is based on PCT boundaries which are no longer relevant.

89. In 2017, we commissioned The King’s Fund to review approaches used to adjust for unavoidable cost differences in other parts of the public sector and in other countries, and to interview trusts’ finance directors for their views about the MFF.

90. We also commissioned Frontier Economics to undertake an independent, comprehensive review of the MFF calculation methodology. Frontier Economics assessed several calculation options for each MFF component.

91. We published the final reports from The King’s Fund and Frontier Economics as part of our October 2018 engagement. We also published details of our proposed changes to the method and data used to calculate the MFF, which largely accepted Frontier Economics’ recommendations.

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11 Available to download from: https://improvement.nhs.uk/resources/201920-payment-reform-proposals/#mff
12 Both Annex DtF and the updated A guide to the market forces factor are available to download from: https://improvement.nhs.uk/resources/national-tariff-1920-consultation/
13 https://improvement.nhs.uk/resources/201920-payment-reform-proposals/#mff
92. These publications were accompanied by two surveys: one on the payment reform proposals as a whole, which included a single question on MFF, and a more detailed MFF-specific survey.

93. In the overall payment reform proposals survey, there was general support for the proposals. However, many respondents had significant concerns.

Support for the proposal to update the market forces factor method and data

<table>
<thead>
<tr>
<th></th>
<th>Strongly support</th>
<th>Tend to support</th>
<th>Neither support or oppose</th>
<th>Tend to oppose</th>
<th>Strongly oppose</th>
<th>Don’t know</th>
</tr>
</thead>
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<tr>
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<td>11%</td>
<td>38%</td>
<td>20%</td>
<td>7%</td>
<td>21%</td>
<td>3%</td>
</tr>
</tbody>
</table>

94. As well as responses to the survey, we also received letters and met with stakeholders to discuss the proposed changes in more detail and understand their views on the proposals.

95. The principal concerns were around the following key themes:

- There was concern that insufficient information was made available to enable accurate assessment of the proposal, specifically the underlying source data and calculation methodology associated with the proposal.
- Several responses argued for the inclusion of private finance initiative (PFI) costs and adjustments for rurality, remoteness and travel time were also requested.
- Concerns were raised that TTWAs did not reflect the local recruitment situation, due to issues such as rurality, providers on TTWA borders, high staff costs in low income areas, or the perceived ‘dilution’ of the London TTWA by labour movements between the fringe and outer London.
- There were concerns that the method did not reflect the differences between inner and outer London high cost area supplements (HCAS) used in the Agenda for Change (AfC) pay system.\(^\text{14}\)

• There was significant support for smoothing ‘cliff edges’ between providers, but some comments that genuine differences should not be smoothed and concerns that the method did not reflect local conditions.

• Opinion varied on the proposed four-year transition period. Some respondents requested to implement the change fully in year one, to redress imbalances which have built up over previous years. Others respondents felt the glide path would be too steep and requested the changes should be capped.

• There was concern that using the General Labour Market method\textsuperscript{15} as a model of salary costs did not consider bank/agency roles and there were suggestions to use a different data source such as AfC, the electronic staff record (ESR) or HCAS.

• London providers and commissioners were particularly concerned about the impact of the proposed MFF values. They felt that:
  – the reference cost index (RCI) for London (when adjusted for the proposed MFF) is higher in London than for the rest of England, meaning London would be under-reimbursed
  – HCAS is not properly reflected in the non-M&D staff index
  – some London providers already have a large deficit which would be exacerbated
  – updating the MFF now would create instability for London providers
  – more work needs to be done before updating the MFF.

96. We carefully considered all the feedback we received. The following points summarise our responses to the feedback:

• To increase transparency and provide further information, in early December 2018 we published the calculation models for the proposed MFF values on the NHS Improvement website and directed stakeholders who had expressed an interest to them.\textsuperscript{16}

• The RCI includes both avoidable and unavoidable costs, so we felt that is not a good benchmark for non-controllable cost differences that the MFF aims to adjust for. We are not persuaded that a higher than average MFF

\textsuperscript{15} The General Labour Market method assumes that private-sector labour markets result in a set of wage rates for locally recruited staff. These wage rates are an area’s ‘going rate’ for each group of workers with a certain set of skills. For more information, see Section 6.1 of Market forces factor review and proposed updates.

\textsuperscript{16} Available to download from: https://improvement.nhs.uk/resources/201920-payment-reform-proposals/#mff
adjusted RCI for London indicates that the MFF method is inappropriate. For example, about 25% of London providers have a MFF-adjusted RCI at or below the average of the rest of England – it is therefore plausible that high RCIs for some London providers reflect controllable cost differences (eg due to different level of efficiencies).

• Our modelling indicates that MFF values for London providers would be lower if the non-M&D staff index was based on HCAS rates only.

• The financial impact of the changes to the MFF would be mitigated to a large extent by the five-year transition to the new values, as well as the proposed smoothing of cliff edges in MFF values between providers located close together. The impact would likely be further mitigated by:
  – our proposals for control totals
  – the pace of change policy for CCG allocations.

• Most of the impact on London providers is due to the data update (mainly due to lower wage differences between London and the rest of England than was the case previously\(^\text{17}\)).

• We considered whether it is appropriate to include PFI in the MFF but, drawing on the work by Frontier Economics, concluded that the MFF was not the best mechanism to address PFI funding.

• We continue to consider TTWAs to be a suitable approximation of local labour markets. TTWAs are produced by the Office for National Statistics and are designed to estimate geographical boundaries of local labour markets. Our proposed approach to smoothing cliff edges would reduce the impact of using TTWAs on providers operating near the boundaries of neighbouring TTWAs.

• We have revised the proposed transition path and propose introducing the new values over five years, in equal steps, rather than the four years we originally proposed. This should give providers more time to plan for the changes in MFF-related tariff income.

97. Above all, we consider that not updating the MFF would lead to an allocation of healthcare funding that does not reflect the latest data on unavoidable costs. This could lead to a misallocation of scarce healthcare resources.

\(^{17}\) Our analysis is supported by other recent research, such as House of Commons Library Briefing Paper Number 7950, 1 August 2018: Labour market statistics: UK regions and countries. http://researchbriefings.files.parliament.uk/documents/CBP7950/CBP-7950.pdf
8. Changes in arrangements for procuring products for the NHS

Proposal

We propose to lower the cost uplift factor to remove around £204 million from the amount covered by the national tariff. This would reflect the reduction in product prices that would arise from the proposal to centrally fund the main overhead costs of Supply Chain Coordination Limited (SCCL).

8.1.1. About this proposal

98. Since 2006, NHS Supply Chain (NHS SC) has supplied capital goods and consumables to providers of services covered by the NTNS (e.g., NHS trusts and NHS foundation trusts as well as independent providers) through an arrangement agreed with DHL. Under this arrangement, products and services procured through NHS SC attract a mark-up on prices. The mark-up covers a significant proportion of NHS SC’s operating costs (around £180 million in 2017/18). However, the DHL contract with NHS SC has now come to an end.

99. To address the recommendations on unwarranted variations set out in Lord Carter’s review on NHS operational productivity, and with the DHL arrangement ending, the Department of Health and Social Care (DHSC) took the opportunity to restructure the NHS SC operating model.

100. A new organisation, NHS Supply Chain Coordination Limited (SCCL), has been set up as part of this restructure. The aim of the new model is to increase NHS purchasing power, give providers access to lower procurement prices (potentially removing mark-ups) and drive efficiencies through product rationalisation.

101. SCCL will manage a number of contracts with “Category Tower” providers, who will be responsible for procuring and supplying products to the NHS, as well as contracts for logistics and IT services to support the Supply Chain. The contracts with those providers has been, and will in future be, competitively procured. The contractual payments made by SCCL to those providers accounts for more than 80% of its cost base and a significant proportion of those costs is attributable to improvements to the Supply Chain infrastructure.
102. We propose to reflect the new arrangements by adjusting the prices to be paid under the 2019/20 NTPS by around £204 million. This adjustment would reflect SCCL costs relating to services covered by the NTPS only.

103. NHS England would adjust commissioner allocations to reflect the SCCL overheads that relate to high cost drugs and devices and CCGs (eg home delivery services) – both being outside the scope of the NTPS. In addition, SCCL would not be funded for costs expected to be covered by other income streams that they are likely to generate, eg rebates from suppliers and income from customers not providing tariff services (who would continue to be charged a mark-up).

104. We propose to make this change by reducing the cost uplift factor. For nationally determined prices, the adjustment would be 0.36%.

105. It is likely that opportunities to use SCCL services will differ between acute, mental health, community and ambulance services – for example, it is likely that acute providers have higher non-pay costs than mental health providers. Table 11 in Section 11.9 summarises the different cost adjustments that should be considered for local pricing of different services.

106. We have used the following method for calculating the adjustment to the cost uplift factor:

- We estimated the amount of the total tariff top slice.
- We then allocated this amount to the different service types (ie acute, ambulance, mental health and community), using trust definitions.
- The resulting amounts were divided by the respective trust income from patient care activities.

107. Table 3 shows the suggested reductions in the cost uplift factor to be used for local pricing, based on different services’ share of SCCL overheads.

**Table 3: Suggested reductions in cost uplift factor for local pricing**

<table>
<thead>
<tr>
<th></th>
<th>Acute</th>
<th>Mental health</th>
<th>Ambulance</th>
<th>Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adjustment to the cost uplift factor</td>
<td>0.36%</td>
<td>0.10%</td>
<td>0.08%</td>
<td>0.05%</td>
</tr>
</tbody>
</table>
8.1.2. Why we think this is the right thing to do

108. We took part in a series of engagement workshops, run by DHSC and SCCL, that covered the rationale for setting up SCCL, the increase in its running cost, the expected benefits for providers of tariff services and the funding model.

109. In *Payment reform proposals 2019/20* we sought feedback on funding SCCL overheads by lowering the amount allocated to national tariff through an adjustment to the cost uplift factor or by SCCL continuing to charge mark-ups on product prices.

110. The feedback was strongly in favour of continuing with mark-ups (184 respondents preferred mark-ups; 55 preferred adjusting the tariff cost uplift factor). While many respondents agreed with the principle and potential benefits of centralising NHS procurement, most felt that funding SCCL by reducing the tariff placed too much financial risk on providers. There were concerns that providers would need to fund an increase in the first year without a guarantee that SCCL would be able to generate additional savings to off-set the incremental overhead costs.

111. However, the associated investments and expected future savings for users of the service would be at risk without central funding of SCCL’s overheads. While we recognise that there is a residual risk on providers, we think that this risk has been mitigated to some extent by adjusting the national tariff only for the relevant proportion of SCCL’s overheads and the opportunity for immediate cost savings (in aggregate) that would arise from removing the mark up.

112. We would review the savings achieved from the proposed new procurement operating model before making any proposals for future tariffs adjustments to cover the SCCL’s overhead costs.
9. Maternity payment pathway

9.1. Making maternity prices non-mandatory

**Proposal**

We propose that maternity services will not be covered by national prices and all maternity pathway prices will become non-mandatory. This is to address a legal issue with the pricing of public health services. Providers and commissioners would be strongly encouraged to continue to use the prices as the basis for maternity services payments.

9.1.1. About this proposal

113. During the development of the 2019/20 tariff proposals, we identified that the maternity pathway prices covered some public health services, which may not be subject to national prices under the Health and Social Care Act 2012.\(^\text{18}\)

114. Currently, the maternity pathway payment incorporates into the integrated package of care offered to pregnant women and their baby, a number of public health services commissioned by NHS commissioners by virtue of arrangements between the Secretary of State and NHS England under section 7A of the NHS Act 2006 (‘Section 7A services’). These services are an established part of clinical practice and it is hard to separate out the costs of many of the Section 7A services from the care routinely provided during pregnancy and the screening and immunisation programmes the newborn baby receives. In most cases, we do not have detailed costing information.

115. We believe application of non-mandatory prices for maternity care would be the most appropriate mechanism to maintain the integrity of the package of care provided to women and newborn babies. Providers and commissioners would be strongly encouraged to adopt the non-mandatory prices in the same way as they use the current (mandatory) national prices.

116. It is important to note that we are considering this change only to address the current mix of services issue. The non-mandatory prices would continue to be calculated using the costs associated with the delivery of the maternity

\(^{18}\) See, in particular, section 116(11) of the 2012 Act.
pathways and would be subject to the same adjustments for the cost base, cost uplift and efficiency factor as national prices (see Section 11).

9.1.2. Why we think this is the right thing to do

117. Before proposing a move to non-mandatory prices, we considered what other approaches could be used to address the issue. We considered removing the relevant services from Section 7A arrangements and commissioning them as NHS services, or removing these services from the maternity pathway currency design. However, it was felt that changing the specification of Section 7A arrangements would risk the delivery of the public health screening programmes contained in the maternity pathway. We also felt that the data available on Section 7A services is not sufficiently detailed to allow for currency redesign.

118. We have discussed the proposed move to non-mandatory prices with a range of stakeholders. While many concerns were raised that it might introduce a risk if local negotiations try to move away from the prices, there was also a general understanding that this would be the most practical approach to the issue for the short term.

119. Feedback from NHS England’s maternity pathway payment system review group, the maternity Expert Working Group (EWG) and the Healthcare Financial Management Association (HFMA) suggested that the change should not result in significant changes or challenges.

120. Responses in the October 2018 survey on payment reform proposals were generally not supportive.

Support for the proposal to make maternity prices non-mandatory

<table>
<thead>
<tr>
<th></th>
<th>Strongly support</th>
<th>Tend to support</th>
<th>Neither support or oppose</th>
<th>Tend to oppose</th>
<th>Strongly oppose</th>
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<tr>
<td>Number</td>
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<td>%</td>
<td>4%</td>
<td>13%</td>
<td>29%</td>
<td>19%</td>
<td>25%</td>
<td>10%</td>
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</tbody>
</table>

121. Respondents expressed concern at the potential for commissioners or providers to use the introduction of non-mandatory prices to negotiate prices that either differ significantly from the non-mandatory prices or would not fairly
manage resources for both parties. One respondent suggested the success of this approach would depend on the relationships between commissioners and providers.

122. Acute providers indicated the use of non-mandatory prices might result in protracted pricing negotiations, especially when transacting with a large number of commissioners. One independent provider suggested non-mandatory prices could make it more difficult when negotiating with large acute providers or commissioners.

123. To help address these concerns, both NHS England and NHS Improvement would strongly encourage commissioners and providers to use the nationally calculated maternity prices.

124. We are also considering longer-term solutions to the issue, including potential legislative changes. The NHS Long Term Plan proposes increased flexibility in the pricing regime, including making it easier to commission Section 7A public health services as part of a bundle with other related services.

9.2. Scope of maternity pathway services

Proposal

We propose to remove specialist fetal medicine from the scope of prices for maternity pathway services. The amount of money allocated for specialist fetal medicine would be removed from the total amount used to calculate prices for the antenatal pathway.

We propose to remove abnormally invasive placenta services from the scope of prices for maternity pathway services. The amount of money identified for abnormally invasive placenta would be removed from the total used to calculate prices for the delivery phase.

NHS England would directly reimburse designated providers for specialist fetal medicine and abnormally invasive placenta services.

Designated providers would operate a networked hub-and-spoke approach.
9.2.1. About this proposal

125. We propose removing specialist fetal medicine from the prices for the maternity pathway services. This would mean the amount of money allocated for the service (£19.3 million) is removed from the total amount used to calculate prices for the antenatal pathway. NHS England Specialised Commissioning would then directly reimburse designated providers in accordance with local pricing rules. NHS England Specialised Commissioning is finalising the list of designated providers, following work with Royal Colleges and a request for providers to self-select.

126. The designated specialist fetal medicine providers would provide clinical leadership and operate a networked hub-and-spoke approach, so that women requiring specialist fetal medicine input can continue to receive most of their care locally.

127. Implementing this proposal would result in a small reduction in the antenatal pathway prices.

128. Abnormally invasive placenta is a rare and dangerous condition affecting around 400 women a year. The safety of these women and their babies is best secured by providing their care during the birth episode in a small number of specialist centres. We propose that NHS England will directly commission and pay for these services from April 2019.

129. This would have a small impact on the delivery phase of the maternity pathway (£5.4 million).

9.2.2. Why we think this is the right thing to do

130. We want to ensure that:

• specialist fetal medicine is provided to all women who require it
• it is delivered in designated specialist centres with the required clinical expertise
• these centres are appropriately reimbursed.

131. We considered continuing to use the current payment approach; however, this has been reported to be the cause of significant provider-to-provider disputes
and aged debt, as the cost of necessary specialist interventions may exceed the price for the antenatal pathway.

132. Our proposal should reduce the number of provider-to-provider transactions. In addition, the hub-and-spoke approach would ensure women receive appropriate care as close to home as possible, while supporting local obstetricians with clinical oversight and training opportunities.

133. There was strong support for this proposal from both providers and commissioners in the October engagement survey.

**Support for the proposal to remove specialist fetal medicine from the scope of national prices**

<table>
<thead>
<tr>
<th></th>
<th>Strongly support</th>
<th>Tend to support</th>
<th>Neither support or oppose</th>
<th>Tend to oppose</th>
<th>Strongly oppose</th>
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<td>26%</td>
<td>39%</td>
<td>5%</td>
<td>2%</td>
<td>9%</td>
</tr>
</tbody>
</table>

134. Respondents asked for consideration to be given to how we can ensure ‘spoke’ service providers are reimbursed by ‘hub’ providers. We are working with NHS England Specialised Commissioning to develop a template service-level agreement (SLA) for hub and spoke providers to use to support appropriate reimbursement for care provided.

135. The proposal to remove abnormally invasive placenta from the scope of the tariff was widely supported in our engagement with the sector.

**Support for the proposal to remove abnormally invasive placenta from the scope of national prices**

<table>
<thead>
<tr>
<th></th>
<th>Strongly support</th>
<th>Tend to support</th>
<th>Neither support or oppose</th>
<th>Tend to oppose</th>
<th>Strongly oppose</th>
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<tbody>
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<td>26%</td>
<td>41%</td>
<td>2%</td>
<td>3%</td>
<td>14%</td>
</tr>
</tbody>
</table>
136. Abnormally invasive placenta is associated with significant risks of maternal, fetal and neonatal morbidity and mortality. Our proposal therefore supports the ambition to reduce maternal and neonatal morbidity and mortality rates by commissioning specialised services.

137. One issue that was raised by survey respondents was the need to ensure there are sufficient specialist centres to prevent women having to travel significant distances to receive care. We are addressing this issue with NHS England Specialised Commissioning.

9.3. **Changing the payment design of the delivery phase of the maternity payment pathway**

**Proposal**

We propose to ensure providers are appropriately reimbursed for complexity during the birth phase by:

- increasing the number of payment levels for delivery from two (with or without complications) to seven, including a price for home-based births.

**9.3.1. About this proposal**

138. There are currently 36 HRGs that relate to birth, which providers report against each month. The current maternity pathway has two levels of payment for the birth episode: with or without complications. All births that involve a caesarean section attract the ‘with complications’ price.

139. We propose to group the birth HRGs into six categories, reflecting clinical complexity (see Table 4). This would be done by the HRG grouper and would not result in increased administrative burden. In future tariffs we will consider moving to 36 payment levels, with a separate price for each birth HRG.

140. The birth payment covers the costs of care until the woman and her well baby are transferred to the community midwifery team. Births taking place at home would have a separate price, calculated using the same process as the 2017/19 ‘without complications’ delivery price and adjusted for 2019/20 in line with other tariff adjustments.

141. This would mean a total of seven prices for the delivery phase.
Table 4: Maternity pathway: six-level payment design for delivery phase

<table>
<thead>
<tr>
<th>HRG</th>
<th>HRG description</th>
<th>Payment category</th>
</tr>
</thead>
<tbody>
<tr>
<td>NZ30C</td>
<td>Normal Delivery with CC Score 0</td>
<td>1</td>
</tr>
<tr>
<td>NZ30A</td>
<td>Normal Delivery with CC Score 2+</td>
<td>2</td>
</tr>
<tr>
<td>NZ30B</td>
<td>Normal Delivery with CC Score 1</td>
<td>2</td>
</tr>
<tr>
<td>NZ31C</td>
<td>Normal Delivery with Epidural or Induction, with CC Score 0</td>
<td>2</td>
</tr>
<tr>
<td>NZ40C</td>
<td>Assisted Delivery with CC Score 0</td>
<td>2</td>
</tr>
<tr>
<td>NZ31A</td>
<td>Normal Delivery with Epidural or Induction, with CC Score 2+</td>
<td>3</td>
</tr>
<tr>
<td>NZ31B</td>
<td>Normal Delivery with Epidural or Induction, with CC Score 1</td>
<td>3</td>
</tr>
<tr>
<td>NZ32B</td>
<td>Normal Delivery with Epidural and Induction, or with Post-Partum Surgical Intervention, with CC Score 1</td>
<td>3</td>
</tr>
<tr>
<td>NZ32C</td>
<td>Normal Delivery with Epidural and Induction, or with Post-Partum Surgical Intervention, with CC Score 0</td>
<td>3</td>
</tr>
<tr>
<td>NZ33B</td>
<td>Normal Delivery with Epidural or Induction, and with Post-Partum Surgical Intervention, with CC Score 1</td>
<td>3</td>
</tr>
<tr>
<td>NZ33C</td>
<td>Normal Delivery with Epidural or Induction, and with Post-Partum Surgical Intervention, with CC Score 0</td>
<td>3</td>
</tr>
<tr>
<td>NZ34C</td>
<td>Normal Delivery with Epidural, Induction and Post-Partum Surgical Intervention, with CC Score 0</td>
<td>3</td>
</tr>
<tr>
<td>NZ40A</td>
<td>Assisted Delivery with CC Score 2+</td>
<td>3</td>
</tr>
<tr>
<td>NZ40B</td>
<td>Assisted Delivery with CC Score 1</td>
<td>3</td>
</tr>
<tr>
<td>NZ41B</td>
<td>Assisted Delivery with Epidural or Induction, with CC Score 1</td>
<td>3</td>
</tr>
<tr>
<td>NZ41C</td>
<td>Assisted Delivery with Epidural or Induction, with CC Score 0</td>
<td>3</td>
</tr>
<tr>
<td>NZ42C</td>
<td>Assisted Delivery with Epidural and Induction, or with Post-Partum Surgical Intervention, with CC Score 0</td>
<td>3</td>
</tr>
<tr>
<td>NZ43C</td>
<td>Assisted Delivery with Epidural or Induction, and with Post-Partum Surgical Intervention, with CC Score 0</td>
<td>3</td>
</tr>
<tr>
<td>NZ50C</td>
<td>Planned Caesarean Section with CC Score 0-1</td>
<td>3</td>
</tr>
<tr>
<td>NZ32A</td>
<td>Normal Delivery with Epidural and Induction, or with Post-Partum Surgical Intervention, with CC Score 2+</td>
<td>4</td>
</tr>
<tr>
<td>NZ33A</td>
<td>Normal Delivery with Epidural or Induction, and with Post-Partum Surgical Intervention, with CC Score 2+</td>
<td>4</td>
</tr>
<tr>
<td>NZ34A</td>
<td>Normal Delivery with Epidural, Induction and Post-Partum Surgical Intervention, with CC Score 2+</td>
<td>4</td>
</tr>
<tr>
<td>NZ34B</td>
<td>Normal Delivery with Epidural, Induction and Post-Partum Surgical Intervention, with CC Score 1</td>
<td>4</td>
</tr>
<tr>
<td>HRG</td>
<td>HRG description</td>
<td>Payment category</td>
</tr>
<tr>
<td>-------</td>
<td>----------------------------------------------------------------------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>NZ42B</td>
<td>Assisted Delivery with Epidural and Induction, or with Post-Partum Surgical Intervention, with CC Score 1</td>
<td>4</td>
</tr>
<tr>
<td>NZ43B</td>
<td>Assisted Delivery with Epidural or Induction, and with Post-Partum Surgical Intervention, with CC Score 1</td>
<td>4</td>
</tr>
<tr>
<td>NZ41A</td>
<td>Assisted Delivery with Epidural or Induction, with CC Score 2+</td>
<td>4</td>
</tr>
<tr>
<td>NZ44B</td>
<td>Assisted Delivery with Epidural, Induction and Post-Partum Surgical Intervention, with CC Score 1</td>
<td>4</td>
</tr>
<tr>
<td>NZ44C</td>
<td>Assisted Delivery with Epidural, Induction and Post-Partum Surgical Intervention, with CC Score 0</td>
<td>4</td>
</tr>
<tr>
<td>NZ50B</td>
<td>Planned Caesarean Section with CC Score 2-3</td>
<td>4</td>
</tr>
<tr>
<td>NZ42A</td>
<td>Assisted Delivery with Epidural and Induction, or with Post-Partum Surgical Intervention, with CC Score 2+</td>
<td>5</td>
</tr>
<tr>
<td>NZ43A</td>
<td>Assisted Delivery with Epidural or Induction, and with Post-Partum Surgical Intervention, with CC Score 2+</td>
<td>5</td>
</tr>
<tr>
<td>NZ44A</td>
<td>Assisted Delivery with Epidural, Induction and Post-Partum Surgical Intervention, with CC Score 2+</td>
<td>5</td>
</tr>
<tr>
<td>NZ50A</td>
<td>Planned Caesarean Section with CC Score 4+</td>
<td>5</td>
</tr>
<tr>
<td>NZ51C</td>
<td>Emergency Caesarean Section with CC Score 0-1</td>
<td>5</td>
</tr>
<tr>
<td>NZ51A</td>
<td>Emergency Caesarean Section with CC Score 4+</td>
<td>6</td>
</tr>
<tr>
<td>NZ51B</td>
<td>Emergency Caesarean Section with CC Score 2-3</td>
<td>6</td>
</tr>
</tbody>
</table>

### 9.3.2. Why we think this is the right thing to do

142. Feedback from our national maternity payment pathway system review group, local maternity system events, the tariff advisory group and HFMA indicated the two-level payment approach used in the 2017/19 NTPS is insufficiently granular and fails to provide appropriate reimbursement for complex deliveries. This feedback was echoed in our tariff engagement workshops, our webinar on proposed changes to the maternity pathway and responses to our engagement survey.
Support for the proposal to have more granular payment levels for the birth episode

<table>
<thead>
<tr>
<th></th>
<th>Strongly support</th>
<th>Tend to support</th>
<th>Neither support or oppose</th>
<th>Tend to oppose</th>
<th>Strongly oppose</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>46</td>
<td>108</td>
<td>39</td>
<td>23</td>
<td>8</td>
<td>17</td>
</tr>
<tr>
<td>%</td>
<td>19%</td>
<td>45%</td>
<td>16%</td>
<td>10%</td>
<td>3%</td>
<td>7%</td>
</tr>
</tbody>
</table>

143. The sector feedback we received indicated a strong support for a payment approach which better reimbursed providers for the care provided to the woman and her baby during labour, birth and the immediate postnatal period.

144. We proposed two options for the payment levels: six or 36. Feedback to our consultation indicated a slight preference for the six-level payment design, although there was some concern that it might lead to an increased administrative burden. We have made clear that the 36 birth-related HRGs will be grouped electronically to the proposed six payment levels and will not require additional coding or administrative resources.

145. Moving to more granular payment levels would reduce prices for the least complex births, including those that take place at home. We asked for feedback on potential mitigation of this impact. Such mitigation was generally supported, with support ranging across providers, commissioners, Royal Colleges and the Maternity Transformation Programme Board.

146. Our proposal to set a separate price for planned home births, based on the 2017/19 ‘without complications’ price (adjusted for 2019/20 in line with other tariff adjustments), reflects the Better Births recommendations to increase the number of births which occur in community settings. We have considered the risk of perverse incentives to encourage clinically inappropriate planned home births, but our judgement is that the risk is unlikely to materialise, as clinicians would continue to advise women on the most clinically appropriate choices.
9.4. Updating postnatal complexities factor

Proposal

We propose to update the complexity factors for the postnatal phase to better reflect the clinical care women require.

We also propose changing the casemix assumptions used to calculate prices for the postnatal phase of the maternity payment pathway.

9.4.1. About this proposal

147. The postnatal phase of the maternity pathway payment begins when the woman and her baby are discharged from the birth setting. The postnatal phase has three levels of payment: standard, intermediate and intensive. The level of payment is determined by clinical and social complexity factors which impact on the intensity of care the woman and her baby will require.

148. We propose to update the complexity factors for the postnatal phase to better reflect the clinical care women require. Table 5 sets out the proposed updates to the factors.

149. In addition, analysis of the maternity dataset has shown that the casemix assumptions used to set prices for the postnatal pathway are incorrect.

150. We therefore propose changing the casemix assumptions used to calculate postnatal prices. This would reflect that more women are assigned to the intermediate or intensive pathway (and corresponding payment level) than is currently assumed in the price calculations. Therefore, each of the postnatal prices would fall slightly to maintain the same overall amount of money allocated to the postnatal phase of the maternity pathway.

Table 5: Postnatal complexity factors (current and proposed)

<table>
<thead>
<tr>
<th>Current complex factors and pathway</th>
<th>Proposed additional complex factors and proposed pathway</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complex social factors</td>
<td>BMI over 50</td>
</tr>
<tr>
<td>Intermediate</td>
<td>Intensive</td>
</tr>
<tr>
<td>Substance use</td>
<td>Age &lt; 16 years***</td>
</tr>
<tr>
<td>Intermediate</td>
<td>Intermediate</td>
</tr>
<tr>
<td>Alcohol use</td>
<td></td>
</tr>
<tr>
<td>Intermediate</td>
<td></td>
</tr>
</tbody>
</table>
Current complex factors and pathway | Proposed additional complex factors and proposed pathway
--- | ---
BMI over 35 and less than 50 | Intermediate | Intermediate
Age < 20 | Intermediate | Intermediate

**Medical factors**

<table>
<thead>
<tr>
<th>Factor</th>
<th>Current Complexity</th>
<th>Proposed Complexity</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV*</td>
<td>Intensive</td>
<td>Neurological disorders</td>
</tr>
<tr>
<td>Renal disease</td>
<td>Intensive</td>
<td>SLE</td>
</tr>
<tr>
<td>Mental health</td>
<td>Intermediate</td>
<td>OASIS/PN bladder dysfunction</td>
</tr>
<tr>
<td>Diabetes or other endocrine disorder</td>
<td>Intermediate</td>
<td>AFLP</td>
</tr>
<tr>
<td>Genetic /Inherited disorder</td>
<td>Intermediate</td>
<td>Postpartum psychosis (Level 2/3 critical care)</td>
</tr>
<tr>
<td>Cardiac disease</td>
<td>Intermediate</td>
<td>Post ITU admission</td>
</tr>
<tr>
<td>Rhesus immunisation**</td>
<td>Intermediate</td>
<td></td>
</tr>
</tbody>
</table>

***During this pregnancy***

<table>
<thead>
<tr>
<th>Factor</th>
<th>Current Complexity</th>
<th>Proposed Complexity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multiple pregnancy</td>
<td>Intermediate</td>
<td>Fetal anomaly</td>
</tr>
<tr>
<td>Gestational hypertension</td>
<td>Intermediate</td>
<td>Cystic fibrosis</td>
</tr>
<tr>
<td>Gestational diabetes</td>
<td>Intermediate</td>
<td>Pulmonary hypertension</td>
</tr>
<tr>
<td>Neonatal death</td>
<td>Intermediate</td>
<td>Peripartum cardiomyopathy</td>
</tr>
<tr>
<td>Still birth or termination after 24 weeks</td>
<td>Intermediate</td>
<td>Transplants</td>
</tr>
<tr>
<td>Pre-eclampsia, eclampsia or HELLP</td>
<td>Intermediate</td>
<td></td>
</tr>
<tr>
<td>Deep vein thrombosis or pulmonary embolism</td>
<td>Intermediate</td>
<td></td>
</tr>
</tbody>
</table>

*HIV data is reported to the MSDS to inform the level of the payment phase. The data is anonymised in accordance with the Data Protection Act 2018 and the General Data Protection Regulation (GDPR); ** Rhesus Immunisation has been recommended for removal *** The addition of the proposed factor of people aged under 16 will not have an effect on the casemix as aged under 20 is already a factor in the pathway

9.4.2. Why we think this is the right thing to do

151. Postnatal complexity factors have not been updated since the maternity pathway was introduced and do not comprehensively reflect current clinical assessment of care needs.

152. In addition, our analysis of the maternity dataset has shown that the casemix assumptions used to set prices are incorrect: there are more women in the intermediate and intensive payment levels than we had anticipated.
153. The feedback we have received on these proposals has been largely positive.

Support for the proposal to update the postnatal complexity factors

<table>
<thead>
<tr>
<th></th>
<th>Strongly support</th>
<th>Tend to support</th>
<th>Neither support or oppose</th>
<th>Tend to oppose</th>
<th>Strongly oppose</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>39</td>
<td>91</td>
<td>72</td>
<td>12</td>
<td>1</td>
<td>24</td>
</tr>
<tr>
<td>%</td>
<td>16%</td>
<td>38%</td>
<td>30%</td>
<td>5%</td>
<td>1%</td>
<td>10%</td>
</tr>
</tbody>
</table>

154. Some respondents expressed concerns at the effect of updating the casemix assumptions and whether the activity is being correctly captured and costed. We are addressing this by working with NHS Digital to revise and improve the currencies and cost collection mechanisms for 2019/20, which will be used to inform future tariffs for postnatal services.
10. Currency design and specification

155. To assist the design of payment for healthcare, we group activity in a clinically meaningful way. These groupings can be used as the basis for the service specifications or ‘currencies’ that may be used to set prices. For example, the groupings used for admitted patient care and outpatient procedures are HRGs.

156. For 2019/20, although we propose that emergency care and maternity services would be removed from the scope of national prices, HRGs would continue to be used as the basis of the unit prices to be used to calculate the blended payment for emergency care, and as the basis for the non-mandatory prices we would publish in relation to maternity services.

157. Outpatient attendances use treatment function codes (TFCs).

158. We need to specify which HRGs and TFCs have national prices. Some HRGs do not have national prices because the reference cost data is not sufficiently robust, for example due to a small number of patients receiving specialised treatment for a rare condition.

159. In this section we explain our proposals on the currencies to be included in the 2019/20 NTPS.

10.1. Currency design

Proposal

We propose to:

- continue using the HRG4+ phase 3 currency design to set national prices, moving to the version used for 2016/17 reference costs
- remove two septic shock HRGs (WJ05A and WJ05B)
- make the currencies for wheelchair and spinal cord injury services national currencies rather than non-mandatory ones.

10.1.1. About this proposal

160. We propose to continue using the HRG4+ phase 3 currency design to set national prices, moving to the version used for 2016/17 reference costs.
161. Due to the difference from the design for 2016/17 reference costs, we propose to remove two septic shock HRGs (WJ05A and WJ05B). New coding guidance for sepsis means it is no longer possible for activity to group to these HRGs. The two HRGs have also been removed from the design for 2017/18 reference costs.

162. We propose that both wheelchair and spinal cord injury services have national currencies from 2019/20 (see Annex DtC). These currencies used to be non-mandatory. Areas are expected to use these currencies to agree local prices for these services or agree a local variation.\(^{19}\) We have proposed non-mandatory prices for wheelchair services (see the supporting document *Non-mandatory currencies and prices*).

10.1.2. Why we think this is the right thing to do

163. NHS Digital’s National Casemix Office is responsible for the design of HRGs. They ensure that all developments are based on clinical advice.

164. We included the proposed move to the HRG4+ phase 3 as used for 2016/17 reference costs in our October 2018 publication, *Payment system reform proposals for 2019/20*. In the accompanying survey, there was a single question asking about the proposed currency design and specification changes. Responses to this question were supportive of the proposals.

<table>
<thead>
<tr>
<th>Support for the currency design and specification proposals</th>
<th>Strongly support</th>
<th>Tend to support</th>
<th>Neither support or oppose</th>
<th>Tend to oppose</th>
<th>Strongly oppose</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
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<td>43</td>
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<td>11</td>
<td>5</td>
</tr>
<tr>
<td>%</td>
<td>24%</td>
<td>51%</td>
<td>17%</td>
<td>2%</td>
<td>4%</td>
<td>2%</td>
</tr>
</tbody>
</table>

165. The HRG4+ phase 3 currency design used for 2016/17 reference costs is the latest available for which we have cost data to set national prices. It updates the version used for 2017/19 prices to address known issues in the design and to incorporate new diagnosis codes (ICD-10 5th edition), National Institute for...

\(^{19}\) More detail on the proposed rules for locally determined prices can be found in Section 6 of the draft 2019/20 NTPS, presented in the second part of this document.
Health and Care Excellence (NICE) guidance, and new datasets (eg the neonatal and paediatric critical care minimum datasets).

166. We consider that the non-mandatory currencies for wheelchair and spinal cord injury services have been tested and proved fit for purpose for a national currency. Mandating these currencies would support more consistent commissioning of services, allow more consistent benchmarking of services, help drive improvements in patient outcomes, allow improved costing to take place, and increase the potential to develop national prices.

10.2. Scope of currencies

Proposal

We propose to:

- set national prices for HRGs and TFCs reflecting the HRG4+ phase 3 currency design, and TFCs for outpatients, used for 2016/17 reference costs
- remove emergency care and maternity services from national prices (and therefore from the currencies for national prices)
- add outpatient procedure prices for five HRGs and remove the price for two outpatient procedures.

10.2.1. About this proposals

167. As set out earlier, we propose to remove the following services from the scope of currencies for national prices:

- emergency care services (see Section 6)
- maternity services (see Section 9).

168. Other than these changes, we propose to set national prices for HRGs and TFCs that had national prices in the 2017/19 NTPS. Where the design of HRGs has changed, we have mapped activity from the old to the new HRGs. For currency changes that remain within the scope of national prices, where all the activity in the new HRG had a national price in the 2017/19 NTPS, we propose a national price in 2019/20. In the few cases where not all the activity in the new HRG had a national price in the 2017/19 NTPS, we propose a national price if the majority of activity had a national price in the 2017/19 NTPS.
169. The overall number of proposed national prices has reduced due to the proposals to remove emergency care and maternity services from the scope of national prices. In addition, there is a net increase of 19 HRGs with national prices in 2019/20 that are due to changes in HRG design: 230 new HRGs and 211 HRGs that have been removed.

170. Most of these changes are a result of changes in chapter F (digestive systems). Codes starting with FZ have been relabelled to start with FD, FE or FF instead. This change accounted for 203 new HRGs with national prices and the removal of 202 HRGs that formerly had national prices.

171. The change in the currency design introduced two new empty core HRGs: RD97Z (diagnostic imaging) and RN97Z (nuclear medicine). As with other empty core HRGs, these have a zero price in 2019/20. Empty core HRGs allow a price to be paid for each scan.

172. Two of the HRGs that no longer have a national price are for septic shock (WJ05A and WJ05B) as these HRGs have been removed. NHS Digital’s coding guidance for sepsis means it is not possible for activity to group to these HRGs.

173. Based on EWG advice, we propose adding outpatient procedure prices for five HRGs and removing the price for two outpatient procedures.

<table>
<thead>
<tr>
<th>Prices added</th>
<th>Prices removed</th>
</tr>
</thead>
<tbody>
<tr>
<td>• EY13Z – Removal of Electrocardiography Loop Recorder</td>
<td>• BZ54B – Major, Orbit or Lacrimal Procedures, 19 years and over, with CC Score 0; and</td>
</tr>
<tr>
<td>• FF14Z – Adjustment of Gastric Band for Obesity</td>
<td>• EY12A – Implantation of Electrocardiography Loop Recorder with CC Score 3+.</td>
</tr>
<tr>
<td>• FE33Z – Therapeutic Flexible Sigmoidoscopy, 19 years and over</td>
<td></td>
</tr>
<tr>
<td>• FE47Z – Combined Upper and Lower Gastrointestinal Tract Therapeutic Endoscopic Procedures</td>
<td></td>
</tr>
<tr>
<td>• FE48B – Combined Upper and Lower Gastrointestinal Tract Diagnostic Endoscopic Procedures with Biopsy, 18 years and under.</td>
<td></td>
</tr>
</tbody>
</table>
10.2.2. Why we think this is the right thing to do

174. Draft price relativities that we proposed for 2019/20 were reviewed by clinicians in the EWGs. We adopted their recommendations for which HRGs should have national prices, and outpatient procedure prices, wherever possible (eg where there was sufficient data to calculate a price).

175. We published draft 2019/20 price relativities as part of our engagement on Payment system reform proposals for 2019/20. All feedback was reviewed. As shown in Section 10.1.2, there was strong support for the currency design and specification changes in the single survey question that covered these together.

176. Updating national prices to take account of the latest HRG currency design, and clinical feedback, helps to provide an efficient allocation of resources between services and between providers.

10.3. Frontloading outpatient attendance prices

Proposal

We propose to change the levels of frontloading between first attendance and follow-up appointments in outpatients for the following areas:

- ophthalmology (decrease from 30% to 20%)
- dermatology (decrease from 30% to 20%)
- urology (decrease from 30% to 20%)
- nephrology (decrease from 10% to 0%).

10.3.1. About this proposal

177. To incentivise a change in the delivery of outpatient follow-up activity, encourage a move to more efficient models and free up consultant capacity, we over-reimburse first attendances and under-reimburse follow-up attendances. This ‘frontloading’ was first introduced in 2012/13 at 10%. In the 2017/19 NTPS, it was increased to between 10% and 30%, based on the following criteria:

- 30% – adult surgical specialties and some medical specialties (eg gastroenterology)
- 20% – other medical specialties, including those treating long-term conditions and clinically requiring many repeat follow-up appointments
• 10% – oncology, haematology, paediatric specialties and areas where we have a best practice tariff (eg transient ischaemic attack).

178. In developing our proposals for the 2019/20 NTPS, we used the principle that the level of frontloading would only change if a significant volume of activity in the specialty would, on its own, fall into a different frontloading band. Our proposed changes account for different mixes between surgical, medical and oncology within the specialty.

179. As such, we propose to reduce the levels of frontloading between first attendance and follow-up appointments for the following services:

• ophthalmology (decrease from 30% to 20%)
• dermatology (decrease from 30% to 20%)
• urology (decrease from 30% to 20%)
• nephrology (decrease from 10% to 0%).

10.3.2. Why we think this is the right thing to do

180. The proposed changes to frontloading levels were informed by NHS Digital National Casemix Office clinical EWGs.

181. EWG feedback for ophthalmology was that 25% of follow-ups are surgical with the rest medical (with relatively little activity for cancer and none in paediatrics). Using the criteria for calculating the frontloading levels, the appropriate frontloading level, weighted by case type, would be around 22.5% (ie one-quarter surgical (30%) and three-quarters medical (20%)). We therefore propose to reduce the frontloading for ophthalmology to 20%.

182. EWG feedback for urology was that about 50% of follow-ups are for cancers. We therefore propose reducing frontloading to 20% (ie one-half at 30% and one-half at 10%).

183. Feedback for dermatology was that repeat follow-ups are often required to deliver ongoing treatment. We therefore propose to reduce the frontloading for dermatology from 30% to 20%.

184. When frontloading was first introduced in 2012/13, it was applied to all TFCs except for nephrology. Following feedback from the EWG, we propose to return the frontloading for nephrology to 0%.
185. We included the proposals to reduce frontloading in ophthalmology, dermatology and nephrology in our October 2018 publication, *Payment system reform proposals for 2019/20*. In the accompanying survey, there was a single question about our proposals for outpatients (including creating new non-mandatory prices – see *Non-mandatory currencies and prices* for details). Responses to this question were supportive of the proposals (see 10.4.2).

186. Some of the comments specifically related to the frontloading changes were supportive of the reductions but requested further reductions back to the 10% level as of 2016/17. Having considered the criteria set out in Section 10.3.1, we did not consider that a further change would be appropriate.

### 10.4. Outpatient attendances

<table>
<thead>
<tr>
<th>Proposal</th>
</tr>
</thead>
<tbody>
<tr>
<td>We propose to specify non-mandatory prices for outpatient attendances for:</td>
</tr>
<tr>
<td>• non-face-to-face follow-ups for specialties with national prices</td>
</tr>
<tr>
<td>• non-consultant-led first and follow-up attendances.</td>
</tr>
</tbody>
</table>

### 10.4.1. About this proposal

187. The 2017/19 NTPS included a set of national prices for first and follow-up attendances for 56 treatment specialties. The difference between first and follow-up prices varies by specialty, with up to 30% of the cost of follow-up attendances front-loaded into first attendance prices. The national prices are for consultant-led, face-to-face attendances.

188. To encourage innovative ways of working, increase clinical capacity and improve access for patients in elective care, we propose to introduce non-mandatory prices for non-face-to-face follow-up and non-consultant-led activity.

189. Non-mandatory prices would give providers and commissioners a starting point for discussions on reimbursing this activity and a guideline on what would be an appropriate level of reimbursement, relative to other national prices.

190. The non-mandatory prices for non-face-to-face activity would apply to all non-face-to-face clinical contacts carried out for the purposes of clinical
consultation, advice and treatment planning. This includes clinical consultations carried out via telephone, telemedicine, video conferencing (such as Skype) and talk type for people who are unable to speak.

191. To qualify for the non-mandatory price, the clinical contact should meet the following criteria:

- The contact is in lieu of a face-to-face contact (i.e., a face-to-face contact would have been necessary if the telephone/video call had not taken place).
- The contact should be pre-arranged with the patient.
- The contact is for healthcare delivery purposes (e.g., advice, counselling etc) and not administrative purposes (e.g., making an appointment, relating the outcome of a care review, discharging the patient).

192. This means the non-mandatory prices would not be applied to telephone calls, emails or texts sent to make an appointment, discharge the patient or relay results.

193. In some cases, a 30-minute face-to-face contact every six months may be replaced by, for example, six, five-minute non-face-to-face contacts each month. In such cases, we would not expect each of these five-minute contacts to attract a full non-face-to-face price. For services where this is likely to happen, either because of the way patient pathways are designed or patient need, we expect providers and commissioners to negotiate and agree how such activity would be reimbursed.

194. In line with the NHS Data Dictionary, definitions for non-consultant-led activity, non-mandatory prices for non-consultant-led attendances will apply to clinical contacts where a consultant does not retain overall clinical responsibility for patient care, the service and professional team or treatment. More detailed definitions of non-face-to-face and non-consultant-led activity can be found in The NHS Data Dictionary.²⁰

195. We also propose to introduce a new non-mandatory price for advice and guidance (see the Non-mandatory currencies and prices supporting document for details).

10.4.2. Why we think this is the right thing to do

196. We want to design a payment mechanism for outpatients which maintains quality of care and:

- incentivises increased use of non-face-to-face (eg telemedicine) and non-consultant-led activity where clinically appropriate
- reduces incentives for unnecessary consultant-led face-to-face activity
- helps support lower unit cost of outpatient services
- helps providers meet the referral to treatment (RTT) standard by freeing up consultant time to deliver more first attendances.

197. The 2017/19 NTPS did not include a non-mandatory price for outpatient attendances, which had been set at £23 in previous tariffs. However, many attendees to our summer workshops reported that the £23 was still being widely used. Part of our intention for 2019/20 is that the new non-mandatory prices will ensure that this is no longer used.

198. Feedback from the sector suggests that the main driver of the cost of an attendance is likely to be consultant time. If the main driver is staff costs, then the cost of an attendance will increase or reduce depending on changes in staff time per consultation. Therefore, we propose that the non-face-to-face price is set at a fixed percentage of the face-to-face price. The reference cost of a non-face-to-face attendance is, on average, 68% of that of a face-to-face attendance. We therefore propose that the non-face-to-face price is set at 68% of the face-to-face price.

199. We included the proposals to introduce non-mandatory prices for this outpatient activity in our October 2018 publication, Payment system reform proposals for 2019/20. In the accompanying survey, there was a single question about our proposals for outpatients Responses to this question were supportive of the proposals.

Support for the proposed changes to outpatients

<table>
<thead>
<tr>
<th>Support for the proposed changes to outpatients</th>
<th>Strongly support</th>
<th>Tend to support</th>
<th>Neither support or oppose</th>
<th>Tend to oppose</th>
<th>Strongly oppose</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>90</td>
<td>119</td>
<td>24</td>
<td>24</td>
<td>11</td>
<td>5</td>
</tr>
<tr>
<td>%</td>
<td>33%</td>
<td>43%</td>
<td>9%</td>
<td>9%</td>
<td>4%</td>
<td>2%</td>
</tr>
</tbody>
</table>
200. Some of the comments questioned why the new prices were not being set as national prices as this would minimise provider and commissioner disagreements. Having considered this view, we felt that setting these prices as non-mandatory for the 2019/20 NTPS would be a positive first step before reviewing how the prices have been used before potentially setting national prices in future tariffs.

201. Both in the survey and during the summer 2018 workshops on initial proposals, we received requests for clarification of what was meant by non-consultant-led and non-face-to-face. We have reviewed the guidance in Annex DtB to ensure the descriptions are accurate, building on the NHS Data Dictionary definitions provided in Section 10.4.1.

202. We are developing further-reaching changes to outpatient payment models for future tariffs to support the radical vision for transforming outpatient services that has been developed in support of the NHS Long Term Plan. We expect to start pilots on new outpatient payment models over the coming months.

10.5. High cost drugs, devices and listed procedures

Proposal

- We propose to update the high cost drugs list by adding 107 drugs and removing 58 drugs.
- We propose to update the high cost devices list by adding five devices and removing one device.
- We propose to add to add two molecular diagnostic tests to the list of high cost procedures.

Annex DtA shows the high cost drugs and devices list with our proposed changes.

10.5.1. About this proposal

203. Several high cost drugs, devices and listed procedures are not reimbursed through national prices. Instead they are subject to local pricing in accordance with the rules set out in Section 6 of the NTPS. When considering which items to include in the lists, our guiding principle has been that the drug or device should be high cost and represent a disproportionate cost compared to the...
other expected costs of care within the HRG, which would affect fair reimbursement.

204. Towards the end of 2017, we launched a web portal on the NHS England website which allowed individuals and organisations to nominate drugs and devices to be added to and removed from the lists.

205. The nominations received were shared with members of the NHS England High Cost Drugs Steering Group and High Cost Devices Steering Group. We then held meetings of these groups to discuss the nominations and make recommendations. In addition, the High Cost Drugs Steering Group undertook some ‘horizon scanning’ to identify drugs not yet in use but which could be added to the list. In August 2018 a further call for nominations for devices to be added to the high cost list was issued.

206. We also worked with NHS England Specialised Commissioning colleagues to review the list of molecular diagnostic tests.

10.5.2. Why we think this is the right thing to do

207. Our October 2018 publication, Payment system reform proposals for 2019/20, set out initial proposals for changes to the high cost drugs, devices and procedures lists:

208. For the high cost drugs list, we initially proposed to:

- add 109 drugs to the list
- remove 47 drugs from the list.

209. For the high cost devices list, we initially proposed to:

- add five devices to the list
- remove one device from the list
- add consumables specifically used for the deployment of listed devices to this list
- expand the guiding principles used to determine the high cost list to support procurement arrangements introduced by NHS England Specialised Commissioning.

210. For the high cost procedures list we initially proposed to:
• remove five molecular diagnostic tests from the list
• retain two molecular diagnostic tests on the list – Oncotype DX and PD-L1
• add two molecular diagnostic tests to the list – EndoPredict and Prosigna.

211. The feedback to the proposals was generally supportive.

Support for the proposed changes to the high cost drugs, devices and listed procedure lists

<table>
<thead>
<tr>
<th></th>
<th>Strongly support</th>
<th>Tend to support</th>
<th>Neither support or oppose</th>
<th>Tend to oppose</th>
<th>Strongly oppose</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
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<td>94</td>
<td>84</td>
<td>15</td>
<td>26</td>
<td>22</td>
</tr>
<tr>
<td>%</td>
<td>6%</td>
<td>37%</td>
<td>33%</td>
<td>6%</td>
<td>10%</td>
<td>8%</td>
</tr>
</tbody>
</table>

212. We discussed the feedback we received from the survey with the respective steering groups and, for the high cost procedures list, with NHS England Specialised Commissioning.

213. A number of respondents felt unable to comment on the proposed high cost drugs list as the draft prices had not been adjusted to reflect drugs being added to or removed from the list. Some respondents also raised concerns about specific drugs which were proposed to be removed from the list, asking how costs associated with the drugs would be appropriately identified and added into national prices. We liaised directly with respondents about issues relating to specific drugs, ensuring that we understood the issues involved and that our proposals were appropriate.

214. There were requests for clarification of the wording around the proposal to include on the list consumables specifically used for the deployment of high cost devices. This was also a topic of debate among attendees at the summer 2018 workshops on initial proposals.

215. Survey respondents raised concerns about funding for the five molecular diagnostic tests that were proposed to be removed from the high cost procedures list. It was suggested that current activity levels are far in excess of those in the reference cost period on which 2019/20 prices are based.
216. Having considered the feedback received, we have made the following changes to the proposals published in October 2018:

- We are not going ahead with the proposal to remove antifungal drugs and botulinum toxin from the high cost drugs list.
- We are not including some drugs which we had proposed to add to the list but which are no longer in development.
- We propose clarifying the wording to make clear that consumables required uniquely for the deployment of listed devices should also be subject to reimbursement outside national prices.
- We no longer propose to remove the five molecular diagnostic tests from the list.

217. The proposed national prices have also been adjusted to reflect the proposed changes to the high cost lists.

218. Annex DtA shows our proposed high cost drugs, devices and listed procedures lists.

10.6. Other cancer multidisciplinary team services

Proposal

We propose to make a further adjustment of £29.7 million to the tariff cost base to reflect the removal of other cancer MDT (multidisciplinary team) services from the scope of the national tariff.

10.6.1. About this proposal

219. In 2017/18 other cancer MDTs were removed from the scope of the nationally priced services element of the NTPS.

220. This was reflected as a scope change in the 2017/19 tariff – cancer MDT services became locally priced services commissioned by NHS England Specialised Commissioning.

221. This necessitated an adjustment to the tariff cost base, as with any other scope change. An adjustment of £46.8 million was therefore made. This adjustment
was based on our best estimate at the time of relevant costs included in nationally priced services.

222. Looking further at the split of outpatient services covered by national prices, it is felt we overestimated the other cancer MDTs costs that were previously included in local pricing arrangements.

223. As a result, we have reviewed our decision in the 2017/19 NTPS and increased our estimate of the proportion of other cancer MDT costs that were previously included in nationally priced services.

224. As a result, we are proposing to further adjust the tariff cost base by £29.7 million.

10.6.2. Why we think this is the right thing to do

225. Multidisciplinary teams are an important element of cancer care. The funding of other cancer MDTs has frequently been raised as an area of concern, both by NHS England Specialised Commissioning and by providers and commissioners. NHS England Specialised Commissioning was reimbursing other cancer MDT services at the level of the cost base adjustment in the 2017/19 NTPS, despite costs being significantly higher. We assumed at the time of the cost base adjustment for 2017/19 that the difference was included in previously locally priced services. Looking further at the split of outpatient services covered by national prices, we concluded we had overestimated the other cancer MDT costs that were previously included in local pricing arrangements.

226. Making this adjustment will allow other cancer MDT services to be more appropriately reimbursed.
10.7. Best practice tariffs

Proposal

- We propose to introduce new BPTs for spinal surgery and emergency laparotomy.
- We propose to update some existing BPTs to reflect new data or clinical best practice.
- We propose to remove the BPT for same day emergency care but that other BPTs that relate to emergency care, in part or in whole, should continue to operate in the context of blended payments for emergency care.

Annex DtD provides detailed guidance on the proposed BPTs for 2019/20.

10.7.1. New best practice tariffs

Spinal surgery

227. We propose to introduce a BPT to encourage submission of data to the British Spine Registry. The BPT would be based on a 50% provider-level case attainment rate for 2019/20 and there would be a 10% differential between the base price and the BPT top-up price.

228. We expect that the case attainment rate will rise to 80% in future tariffs. This reflects the current low average case attainment rate (around 20%).

229. This proposal follows a recommendation from the Getting It Right First Time (GIRFT) team that use of the British Spine Registry (BSR) should be increased. In the October 2018 survey on our proposals, there was a single question on the BPT proposals (see below for feedback of responses). Based on the comments submitted as part of the survey, there was overall support for this BPT from providers and commissioners.

230. Some providers raised concerns about data quality, the availability of timely reporting to support payment and whether the new BPT would lead to increased administration burden. These issues have been frequently raised about other BPTs and are key considerations in the design of new ones. We have sought to address these concerns by putting in place a process through which BSR data is validated by cross-referencing with commissioning data using the National Commissioning Data Repository (NCDR).
Emergency laparotomy

231. In England, approximately 30,000 emergency laparotomies (emergency operations on the bowel) are undertaken annually on a diverse cohort of patients. Improving practice in this area through a BPT was strongly supported by respondents to the October 2018 survey.

232. We propose to introduce a BPT to increase the proportion of patients whose emergency laparotomy surgery is directly supervised by both a consultant surgeon and a consultant anaesthetist, and who are transferred directly to a critical care unit from theatre.

233. To qualify for the BPT, 80% of applicable patients (as reported by the National Emergency Laparotomy Audit (NELA)) must receive both consultant presence and critical care admission. Providers must also have trust-wide multidisciplinary care pathways in place.

10.7.2. Updates to existing best practice tariffs

234. We propose to update some existing BPTs to reflect new data or clinical best practice.

235. Table 6 outlines the proposed changes. Annex DtD sets out the updated guidance on BPTs. For BPTs that relate to emergency care in part or in whole, our supporting document, Guidance on blended payment for emergency care, provides details of how we propose they would operate in the context of blended payments for emergency care.

236. For the 2019/20 NTPS, we propose to remove the table summarising BPT eligibility criteria from the tariff document and instead ask people to refer to the guidance in Annex DtD. We hope that this would ensure people access all the information they need to implement the BPTs.

237. We propose to retire the BPT for same day emergency care as the aims of this BPT are built into the design of the blended payment system for emergency care (see Section 6).
Table 6: Proposed updates to existing best practice tariffs

<table>
<thead>
<tr>
<th>BPT</th>
<th>Proposed changes for 2019/20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute stroke</td>
<td>• We propose to change the element relating to patients being seen by a stroke consultant within 14 hours of admission.</td>
</tr>
<tr>
<td></td>
<td>• This would be amended to:</td>
</tr>
<tr>
<td></td>
<td>– Patients to be assessed within 14 hours of admission by a consultant with stroke specialist skills, at the bedside, by telemedicine (as defined by the Sentinel Stroke National Audit Programme (SSNAP)(^2)) or by telephone with access to picture archiving and communication systems (PACS) imaging.</td>
</tr>
<tr>
<td></td>
<td>– All patients must have a bedside assessment by a stroke consultant within 24 hours of admission to hospital.</td>
</tr>
<tr>
<td>Day-case procedures</td>
<td>• We propose to:</td>
</tr>
<tr>
<td></td>
<td>– include eight new clinical scenarios in the scope of the BPT</td>
</tr>
<tr>
<td></td>
<td>– increase the target rates for 17 procedures</td>
</tr>
<tr>
<td></td>
<td>– retire 13 procedures, where the targets have converged to the recommended target rate and day case is now standard clinical practice.</td>
</tr>
<tr>
<td>Endoscopy procedures</td>
<td>• We propose to amend the status-level descriptions in line with the recommended accreditation status changes being made by the Joint Advisory Group on GI Endoscopy (JAG).</td>
</tr>
<tr>
<td>Early inflammatory arthritis</td>
<td>• We propose to retire the ‘diagnosis and discharge’ and ‘biological therapy’ elements and move away from a year of care payment.</td>
</tr>
<tr>
<td></td>
<td>• We propose to update the BPT to cover the first three months of care only.</td>
</tr>
<tr>
<td></td>
<td>• We propose the BPT is updated to a single conditional higher price (providers would be paid the relevant national tariff for the activity, and then receive a top-up payment if they meet the BPT conditions).</td>
</tr>
</tbody>
</table>

### Major trauma

We propose to update the BPT in the following ways:

- **At level 1:**
  - updating the existing metric relating to the rehabilitation prescription
  - removing the existing metric relating to tranexamic acid in three hours with a new metric introduced in level 2
  - adding a new metric relating to documented evidence of consideration of intubation within 30 minutes, where Glasgow Coma Score (GCS) <9.
- **At level 2:**
  - removing the metric relating to non-emergency transfers as this is a duplicate of level 1
  - adding two new metrics:
    - administration of tranexamic acid within one hour of arrival;
    - patients over 65 having a clinical frailty scale completed within 72 hours of admission.

### Paediatric diabetes

- We propose to align the BPT with the National Paediatric Diabetes Audit (NPDA),22 updating the wording of the criteria and adding information sources to validate compliance.
- The updated BPT will:
  - introduce into the criteria participation in self-assessment, network peer review and quality improvement initiatives
  - increase required participation in regional network meetings from 60% to 75%
  - include patient-related experience measurement (PREM) in the criteria as part of the NPDA participation

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<table>
<thead>
<tr>
<th>BPT</th>
<th>Proposed changes for 2019/20</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>make clear the BPT payment doesn’t cover continuous glucose monitoring systems when used continuously for therapeutic purposes.</td>
</tr>
<tr>
<td></td>
<td>We propose to amend the BPT to support participation in any suitable quality improvement programme in response to feedback from both commissioners and providers challenging the specification of a single quality improvement programme provider.</td>
</tr>
<tr>
<td>Paediatric epilepsy</td>
<td>We propose moving to a three-tier design for the BPT:</td>
</tr>
<tr>
<td></td>
<td>– Tier 1: where a provider is unable to demonstrate compliance with the BPT.</td>
</tr>
<tr>
<td></td>
<td>– Tier 2: where a provider is able to demonstrate compliance with the mandated BPT criteria.</td>
</tr>
<tr>
<td></td>
<td>– Tier 3: a non-mandated tier where a provider is able to demonstrate compliance with mental health provision.</td>
</tr>
<tr>
<td></td>
<td>We propose to amend the existing criteria to reflect the new Epilepsy12 audit (self-assessment measures).23 Full participation in the Epilepsy12 audit will become a requirement.</td>
</tr>
<tr>
<td>Primary hip and knee replacement outcomes</td>
<td>We propose to introduce an extra criterion for primary hip replacement:</td>
</tr>
<tr>
<td></td>
<td>– At least 80% of patients aged 70 and over receive a cemented or hybrid prosthesis.</td>
</tr>
<tr>
<td></td>
<td>We are also proposing to change the national variation supporting this BPT so that it is no longer transitional.</td>
</tr>
<tr>
<td>Rapid colorectal diagnostic pathway (straight to test (STT))</td>
<td>We propose to update the BPT to reflect the experiences of clinicians operating STT pathways. We have taken advice from the Joint Advisory Group (JAG) and British Society of Gastroenterology (BSG).</td>
</tr>
<tr>
<td></td>
<td>We propose to update the pathway to:</td>
</tr>
<tr>
<td></td>
<td>– better define the triage element</td>
</tr>
</tbody>
</table>

23 [www.rcpch.ac.uk/epilepsy12](http://www.rcpch.ac.uk/epilepsy12)
<table>
<thead>
<tr>
<th>BPT</th>
<th>Proposed changes for 2019/20</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>– introduce consultant-led virtual review (after diagnostic test) before endoscopic, radiological and histology results are conveyed to the GP and patient</td>
</tr>
<tr>
<td></td>
<td>– include onward referral, where required, to medical gastroenterology or another relevant specialty or multidisciplinary team</td>
</tr>
<tr>
<td></td>
<td>– include discharge back to GP care with a letter detailing what has been found and what, if any, management is required.</td>
</tr>
</tbody>
</table>

Same-day emergency care

- We propose to remove this BPT.
- We have not received any objections to the suggested removal after discussing it with the steering groups responsible for providing advice and discussion supporting this BPT.

10.7.3. Why we think this is the right thing to do

238. In *Payment system reform proposals for 2019/20* we set out our intention to update some existing BPTs, but did not provide details of the proposed changes. There was a single question on BPTs, covering both the proposed new BPTs and updates to existing ones, and responses were generally supportive.

Support for the proposed changes to BPTs

<table>
<thead>
<tr>
<th></th>
<th>Strongly support</th>
<th>Tend to support</th>
<th>Neither support or oppose</th>
<th>Tend to oppose</th>
<th>Strongly oppose</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>38</td>
<td>106</td>
<td>71</td>
<td>12</td>
<td>3</td>
<td>23</td>
</tr>
<tr>
<td>%</td>
<td>15%</td>
<td>42%</td>
<td>28%</td>
<td>5%</td>
<td>1%</td>
<td>9%</td>
</tr>
</tbody>
</table>

239. The following key themes emerged from the feedback:

- Increased administration burden – this is a common concern, even when the goals of the BPT is strongly supported.
- Data quality, validation, and timely reporting – these are frequently seen as key requirements for all BPTs.
• Use of national audits/registries is seen as positive as it can support payment, reduce the need for local negotiation and enable national comparisons.

• There is support for routine review and updates of existing BPTs to ensure they achieve their intended purpose and are considered for retirement when the change is embedded as standard practice.

240. We have considered this feedback and reviewed our BPT proposals. We have tried, when creating or updating BPTs, to ensure the benefits can be realised without undue administrative burden and, where possible, have aligned BPTs with national audits and registries. We will also support organisations to ensure timely, accurate reporting, through our pricing enquiries function (please email pricing@improve.nhs.uk).

10.8. Innovation and technology tariff

Proposal

We propose to remove reference to reimbursement arrangements for the innovation and technology tariff (ITT) in the NTPS.

10.8.1. About this proposal

241. In 2017/19 we introduced an innovation and technology tariff (ITT) with the aim of setting incentives to encourage the uptake and spread of innovative medical technologies that benefit patients.

242. Since the introduction of the ITT, further developments have taken place to the national approach to supporting the adoption of innovation, most notably the Innovation and Technology Payment (ITP).

243. We therefore propose to remove reference to reimbursement arrangements for the ITT in the NTPS, although prostatic urethral lift systems will continue to be recognised in national prices. ITT/ITP will continue to be paid for directly by NHS England.
10.8.2. Why we think this is the right thing to do

244. Since the introduction of the ITT, there have been a number of developments, including the ITP, to the national approach to supporting the adoption of innovation.

245. The ITP builds on the ITT and gives greater flexibility to support the introduction of both medical and digital technologies. It also allows greater alignment with the ambitions set out in the NHS Long Term Plan.

246. Innovation continues to be an essential aspect of improving healthcare delivery and should be a core part of all work plans.

247. A new selection of ITP innovations will be available from April 2019.
11. Proposed method for determining national prices

11.1. Introduction

248. In this section we present our proposals for setting final national prices for 2019/20. As set out in Sections 6 and 9, we propose that emergency care and maternity services are no longer in the scope of national prices. However, the unit prices to be used for the emergency services payment arrangements and the non-mandatory prices for maternity services have been set using the same process as for national prices.

11.1.1. Our principles

249. We propose to continue using the following principles for setting national prices:

- Prices should reflect efficient costs. This means that the prices set should:
  - reflect the costs that a reasonably efficient provider ought to incur in supplying services at the quality expected by commissioners
  - not provide full reimbursement for inefficient providers.

- Prices should provide appropriate signals by:
  - giving commissioners the information needed to make the best use of their budgets and enabling them to make decisions about the mix of services that offer most value to the populations they serve
  - incentivising providers to reduce their unit costs by finding ways of working more efficiently
  - encouraging providers to change from one model of delivery to another where commissioners want this and where it is more efficient and effective.
11.2 Setting prices for 2019/20

Proposal

- We propose to set prices for the 2019/20 NTPS using currencies set out in Section 10, using largely the same method as for the 2017/19 NTPS.
- The major difference is that national prices would be calculated by reference to costs both within and outside the scope of national prices. We propose to include emergency care and maternity services in price calculations, and related adjustments, despite the proposals for these services to cease to be subject to national prices (see Sections 6 and 9).

11.2.1 About this proposal

250. We propose to set national prices for 2019/20, modelled from the currency design set out in Section 10 of this document, with 2016/17 cost and activity data. The proposed methodology for the tariff model for 2019/20 national prices closely follows the methodology previously used by the then Department of Health Payment by Results (PbR) team, up to 2013/14, and previous national tariffs, including the 2017/19 NTPS.\(^\text{24}\)

251. It was not always possible to exactly replicate the PbR method. However, for the 2014/15, 2015/16 and 2016/17 national tariffs, there were minimal changes, other than to reflect updates to currencies, cost uplifts, efficiency and manual adjustments. For the 2017/19 NTPS, we made some changes, including removing calculation steps that did not have any clearly identifiable policy intention (such as adjustments that appeared to be historic manual adjustments).\(^\text{25}\) Where are proposing to significantly deviate from the method used for the 2017/19 NTPS, we have set out the changes here.

252. We propose to set prices for 2019/20 using the following process:

- Determine price relativities (based on average unit costs), using cleaned 2016/17 reference costs and Hospital Episode Statistics (HES) data as key inputs to calculate average costs for each currency (eg HRG) (see Section 11.3).

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\(^{24}\) For a description of the 2013/14 PbR method, please see Payments by results, step by step guide: calculating the 2013/14 national tariff.

\(^{25}\) For details of these changes, see paragraphs 186-187 of the 2017/19 NTPS.
• Adjust the prices calculated in the first step to an appropriate base year. As price relativities are based on 2016/17 reference costs, we need to adjust them to the current year (2018/19) before we can make any forward-looking adjustments. To do this we adjust the draft prices by applying the efficiency, inflation and Clinical Negligence Scheme for Trusts (CNST) adjustment factors for 2017/18 and 2018/19. At this point we also reduce all admitted patient care prices by the same percentage (a top-slice) to be reallocated for top-up payments for specialised services (see Section 12.2).

• Apply manual adjustments to modelled prices, based on clinical advice, to reduce the number of instances where price relativities are implausible, illogical or distorted (see Section 11.5).26

• Apply the first element of the cost base adjustment factors to prices to ensure prices reimburse a total amount of cost equal to the previous tariff (see Section 11.6).

• Use adjustment factors to increase or decrease the total amounts allocated to specific areas (clinical sub-chapters and/or points of delivery), where appropriate, in line with agreed policy decisions or clinical advice. The amount allocated is draft prices multiplied by 2016/17 activity. These proposed factors would be applied using a proposed new cash in/out approach (see Annex DtF). The changes would be based on the percentage difference between the initial amounts allocated and the desired amounts by point of delivery and/or subchapter, with the prices changed by the same percentage. Examples of these proposed changes include:
  – the second element of the cost base adjustment, which is to increase non-elective and A&E prices for the £1 billion transferred from the PSF
  – continuing the agreed transition path to account for price volatility associated with the move to HRG4+ and the prescribed specialised services (PSS) in the 2017/19 NTPS (see Section 12.2)

• Apply the third element of the cost base adjustment, which is to reflect the transfer of funding from Commissioning for Quality and Innovation (CQUIN) (see Section 11.6). This is done at the same time as adjusting prices to proposed 2019/20 levels to reflect cost uplifts and adjustments (see Section 11.7) and an estimation of the level of efficiency that we expect providers to be able to achieve in 2019/20 (see Section 11.8).

26 An example of an illogical relativity could be where the price for a more complex treatment is lower than the price for a less complex treatment without good reason.
253. This means we propose to set 2019/20 prices using the modelling approach previously used by the then Department of Health for the 2013/14 PbR national tariff, with some method changes and adjustments to allow us to use up-to-date inputs and calculation models, as set out in Section 11.3.

254. When implementing the PbR method for the 2019/20 NTPS, we propose to continue to make minor improvements to the calculation setting process. For example, in the process of updating the tariff calculation model (described overleaf), we were able to increase the accuracy of the trimpoints used for a number of excess bed days.

255. The most significant change in our proposed methodology from the 2017/19 NTPS process is including maternity services and emergency care in price calculations and related adjustments. Despite our proposals for these services to cease to be covered by national prices (see Sections 6 and 9), the costs and related data for those services would be used in the method described in paragraph 252. The resulting prices, while not national prices, would then be used as the unit prices which underpin the emergency services payment approach (see Section 7 of the draft 2019/20 NTPS) and the non-mandatory prices for maternity services (see the supporting document Non-mandatory currencies and prices).

256. The other main differences in our proposed methodology from the 2017/19 NTPS process are as follows:

- Strengthened qualitative review of price relativities by NHS Digital’s National Casemix Office’s clinical Expert Working Groups (EWGs), including reviews of two sets of draft prices.
- Increased specificity in how total amounts of money are adjusted for changes in the scope of the tariff.27
- Using the proposed methodology for calculating MFF values (see section 7).
- Incorporating proposed revisions to the PSS eligibility lists, rules and hierarchy.
- Including the proposed transfer of £1 billion from the PSF into non-elective and A&E prices.

27 This is done through a cash in/cash out process. Annex DtF includes a summary of the proposed cash in/cash out adjustments.
257. We also propose changes to the manual adjustment process, including introducing a standardised approach to treating prices based upon very small numbers of cases (see Section 11.5).

258. While the proposed underlying methodology has remained similar to previous years, for 2019/20 we have rewritten the software infrastructure used to calculate the prices, creating the model in the SAS software package, rather than a mix of SQL and Excel that was used previously. The SAS code for the model is available in Annex DtF.

11.2.2. Why we think this is the right thing to do

259. We believe it is appropriate to continue to use the PbR method to set prices. This long-established method is based on the national reference costs data provided by the NHS, the most comprehensive cost data currently available, which is also quality assured. Using the same method as in previous years also maintains the price stability that the sector needs in agreeing contracts locally while allowing the tariff to support the delivery of major policy changes such as the update to the MFF and the blended payment for emergency care. We have proposed improvements to the method where we have identified errors, to reflect updated data or to ensure the software infrastructure is as reliable as possible.

260. We propose to include the costs of emergency care and maternity services within the modelling process for national prices for the following reasons:

- This ensures that the unit prices to be used in the emergency care payment approach and the non-mandatory prices recommended for use in maternity services are modelled using the same method and to the same standard as national prices. This is to give commissioners and providers confidence that these prices could be used for the purposes of determining local prices (in the case of emergency services, in accordance with the new rules set out in Section 7 of the draft 2019/20 NTPS).
- Removing maternity services and emergency care would have an impact on national prices. The current policies to reduce year-on-year volatility and to set the overall cost base factor include maternity and emergency costs. Removing them from the scope of calculation could lead to higher levels of price volatility. We propose to continue modelling prices using costs from the maternity pathway and emergency care. Removing them from the cost base
used to calculate prices would have an undesirable destabilising effect on other prices.

11.3. Managing model inputs for 2019/20

Proposal

- We propose to use 2016/17 cost and activity data to model prices for the 2019/20 NTPS.
- We propose to clean the reference cost data used and to use activity data grouped by NHS Improvement.

11.3.1. About this proposal

261. We propose to use two main data inputs to generate prices for the 2019/20 NTPS:

- costs – 2016/17 reference costs
- activity – 2016/17 hospital episodes statistics (HES) and 2016/17 reference costs.

262. As in the 2017/19 NTPS, we propose cleaning the reference cost data used for admitted patient care prices. Applying the data cleaning rules would exclude the following records from the raw reference cost dataset:

- Outliers, detected using a statistical outlier test known as the Grubbs test (also known as the ‘maximum normed residual test’).
- Providers that submitted reference costs more than 50% below the national average for more than 25% of HRGs as well as 50% higher than the national average for more than 25% of HRGs submitted.
- Providers that submitted reference costs containing more than 75% duplicate costs across HRGs and departments.

263. We propose merging data where:

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28 See 2016/17 reference costs
29 ‘Cleaning’ is a process of removing potentially implausible records
• prices would have been based on a very low number of spells (less than 50), unless we have been advised otherwise by the EWGs

• illogical relativities were found – for example, where a more complex HRG had a lower cost than a less complex HRG.

264. We propose to use 2016/17 HES data for activity, grouped by NHS Improvement using the 2016/17 (HRG4+) various groupers and the 2019/20 engagement grouper.

265. Using NHS Improvement grouping is a change from the 2013/14 PbR method, which used HES data grouped by NHS Digital.

266. We propose using 2016/17 patient-level cost data to augment the reference cost data in some places. For example, we propose using patient-level cost data to set ‘normative prices’ for a small number of orthopaedic HRGs. These prices would be based on expected clinical practice, informed by a detailed review of reference cost and patient-level cost data for a random sample of 30 patients in each of 15 trusts for five common orthopaedic procedures. Each review team comprised the orthopaedic EWG representative, trust representatives (a senior orthopaedic surgeon, head of clinical records, head of costing and a representative from finance) and NHS Improvement staff.

11.3.2. Why we think this is the right thing to do

267. We have proposed using 2016/17 cost and activity data because it was the most recent quality assured data available to us at the point of price modelling. This is consistent with previous tariffs. 2016/17 reference cost data is very closely aligned with the proposed currency design of the 2019/20 NTPS.

268. Cleaning reference cost data would reduce unexplained tariff price volatility. We expect that using cleaned data would, over time, reduce the number of illogical cost inputs (for example, fewer very-low-cost recordings for a particular service and fewer illogical relativities). This, in turn, should reduce the number of modelled prices that require manual adjustment and should therefore increase the reliability of the tariff. We believe this benefit outweighs the disadvantage of losing some data points as a result of the data cleaning process.

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30 An illogical relativity is where the cost of performing a more complex procedure is lower than the cost of performing a less complex procedure (without good reason).
269. We propose to use activity data grouped by NHS Improvement, rather than NHS Digital because:

- it allows us more flexibility in the timing of grouping the data
- NHS Digital uses patient-identifiable data for grouping, which cannot be shared with third parties (to protect patient confidentiality). NHS Improvement’s method does not use patient-identifiable data.

270. The NHS Improvement grouping method aims to follow, as closely as possible, the NHS Digital grouping method. Initial analysis indicates that the differences between the two grouping methods are very small.

271. We propose to use patient-level cost data to augment reference costs for a small number of HRGs as it provides more detailed, granular data. This should enable prices to more accurately reflect actual costs. We will continue to look at how we can incorporate the increasing availability of patient-level cost data in our calculation process for future tariffs.

11.4. Setting prices for best practice tariffs for 2019/20

Proposal

We propose to use largely the same method for setting prices for best practice tariffs as we used in the 2017/19 NTPS.

11.4.1. About this proposal

272. As far as possible, we propose to apply a standard method of pricing BPTs. This is largely the same as that used in the 2017/19 NTPS. This involves:

- using the modelled price without adjustments as the starting point
- setting a fixed differential between the BPT and non-BPT price (either a percentage or absolute value)
- setting an expected compliance rate that would be used to determine final prices
- calculating the BPT and non-BPT price so that the BPT would not add to or reduce the total amount paid to providers at an aggregate level.
273. For 2019/20, we propose to amend the methodology used to calculate the day case BPT so it aligns with this approach. We also propose to update the calculation of the endoscopy BPT so that the differentials are the intended 2.5% and 5%, rather than the 4% and 8% that had been used.

274. As set out in Section 6, we propose that BPTs that relate to emergency care in part or in whole are included within the blended payment agreement. We have not changed the approach to calculating these BPT prices.

11.4.2. Why we think this is the right thing to do

275. Our proposed pricing method for BPTs is consistent with that used for the 2017/19 NTPS, apart from where we have responded to anomalies identified through feedback.

276. The suggested updates to the endoscopy BPT will align the calculation method and the intended policy.

277. The proposed updates to the day case BPT calculations will take into account latest data on attainment rates in order to set challenging but achievable target rates for the BPT.

11.5. Making manual adjustments to prices

Proposal

We propose to make manual adjustments to price relativities, following feedback on initial draft prices.

11.5.1. About this proposal

278. As in previous years, the prices published as part of this consultation include manual adjustments to the modelled prices. Here we summarise our proposed approach to manual adjustments.

279. We propose some improvements in the process of making manual adjustments to the price relativities generated by our model. With the NHS Digital Casemix team, we agreed the following approach to initial manual adjustments on modelled prices prior to engaging with EWGs and the sector.
280. We applied manual adjustments where price relativities are likely to be affected by very low activity numbers that could result in less robust reference cost data. Specifically, we set prices to the weighted average of day-case/elective (DC/EL) and non-elective prices (NE) in any of the following scenarios: 31

- DC/EL activity is less than 50.
- NE activity is less than 50.
- DC/EL is less than 3% of DC/EL and NE total activity.
- NE is less than 3% of DC/EL and NE total activity.

281. For HRGs that have high cost devices excluded in national prices, we applied manual adjustments to exclude reference cost data above a set value, suggested by NHS Digital Casemix to be highly likely to include the device cost. Where devices should be included in national prices, we applied manual adjustments to exclude costs below a set value that is likely to exclude the device cost.

282. We applied manual adjustments to exclude outlier costs for 12 HRGs where one provider’s costs, in our view, were likely to be inaccurate and distorted the national price relativities.

283. Where the relevant specialty’s outpatient attendance price was higher than the outpatient procedure price in the same TFC, we manually adjusted the latter based on the weighted relevant outpatient attendance first/follow-up price.

284. We subsequently engaged with representatives of medical colleges, associations and societies through their respective EWGs. This allowed us to sense check the first version of the draft prices. Prices were manually adjusted based on the comments received from the EWGs. 32

285. We accepted proposed adjustments to make prices more reflective of clinical resource requirements. Where manual adjustments increased the total amount allocated to a particular service, these were offset by reductions elsewhere in the HRG chapter or sub-chapter.

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31 Please note: these changes were made before the proposed transfer of £1 billion into non-elective prices (see Section 11.2).
32 Please note: we did not engage on the blended payment policy with the clinical EWG as part of the manual adjustment process.
286. These adjustments and those described above based on low activity levels and implausible costs were included in a set of draft price relativities that were used for a second round of engagements with EWGs and were published in October 2018 as part of our engagement on payment reform proposals.

287. Following feedback on these price relativities, further manual adjustments were made to address illogical relativities. Adjustments were also made to ensure that key prices met clinical resource requirements.

288. We propose that the manual adjustments made to the proposed prices in this consultation notice, and explained above, would be included in the final national prices.

11.5.2. Why we think this is the right thing to do

289. Manual adjustments are made to minimise the risk of setting implausible prices (eg prices that have illogical relativities with other prices). Such prices could negatively impact patient care and service viability. Implausible prices may arise due to, for example, variable quality in reference cost data or rapid change in the level of resource required to deliver care in a particular HRG due to changes in clinical practice.

290. We made initial manual adjustments to account for low activity levels and implausible costs to improve accuracy.
11.6. Cost base

Proposal

For 2019/20, we propose to maintain our historic method for setting the tariff cost base (ie to equalise the cost base to the cost base of the previous tariff, adjusted for activity and scope changes) with three important changes:

- An increase in the cost base of around 1.25%, reflecting an equivalent reallocation of CQUIN funding to the tariff.
- The cost base would no longer apply solely to nationally priced services but would also apply to maternity and emergency care services as well as nationally priced services.
- A £1 billion increase in the cost base to reflect a proposed equivalent reduction in the PSF. We propose to apply this increase only to A&E and non-elective prices.

11.6.1. About this proposal

291. The cost base is the level of cost the tariff will allow providers to recover before making adjustments for cost uplifts and before applying the efficiency factor. In setting national prices, after setting price relativities, we set prices at a level that will allow providers to recover the cost base. We then adjust those prices to allow for cost uplifts and the efficiency factor.

292. As with many other parts of tariff setting, we use the previous year’s tariff as a starting point for the following tariff. Therefore, 2018/19 prices and revenue are used as a starting point.

293. After setting the starting point, we consider new information and several factors to form a view whether an adjustment to the cost base is warranted.

294. Information and factors that we considered include:

- historical efficiency and cost uplift assumptions
- latest cost data
- additional funding outside the national tariff
- changes to the scope of the national tariff, specifically for emergency care and maternity
- any other additional revenue providers use to pay for tariff services
• our pricing principles and the factors that legislation requires us to consider, including matters such as the importance of setting cost-reflective prices and the need to consider the duties of commissioners in the context of the budget available for the NHS.

295. For 2019/20, it is our judgement that it is appropriate to keep the cost base equal to the revenue that would be received under 2018/19 prices (adjusted for activity and scope changes), with the following proposed changes:

• An increase in the cost base of around 1.25% to reflect the equivalent amount reallocated from CQUIN. We propose to apply this amount to all prices (both locally and nationally priced services) by making an adjustment in addition to the cost uplift factor in the tariff.  

• To continue to include emergency care and maternity services within the scope of the cost base.

• £1 billion transferred from the PSF. We propose to apply this increase only to A&E and non-elective prices.

11.6.2. Why we think this is the right thing to do

296. In judging where to set the cost base, we consider the effect of setting the cost base too high or too low. This effect is asymmetric:

• If we set the cost base too low (ie we set too high an expectation that providers will be able to catch up to past undelivered efficiency), providers would have a greater risk of deficit, service quality could be lower than would otherwise be the case (eg increased emergency waiting times), and some providers might cease providing certain services.

• However, if we set the cost base too high, commissioners, who have an obligation to stay within their budgets, are likely to restrict the volumes of commissioned services, and could cease commissioning certain services entirely. This would reduce access to healthcare services.

297. We propose to transfer funding from CQUIN to the cost base as we have previously set the cost base recognising that providers receive revenues in

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33 This is an adjustment to the tariff cost base, as funding is moving into national prices from outside the NTPS. However, the cost uplift factor is being used to make the adjustment in the tariff. This enables it to be applied to local prices, in line with local pricing rule 2.

34 The £1 billion transfer from PSF would be applied to non-elective and A&E prices, not including excess bed days. This would avoid elective prices increasing as a result.
addition to tariff revenues. We are proposing to effect this cost base change through an adjustment in addition to the cost uplift factor as this will ensure that the change to CQUIN funding is applied to all prices (both locally and nationally set). We think this approach minimises transactional burdens in the implementation stage when agreeing local prices. This approach would reduce the risk of financial volatility as most of the relevant elements of CQUIN were previously allocated on the basis of contract value.

298. We propose to transfer money from PSF into prices for emergency care. This approach reduces the risk of financial volatility as PSF allocations were made on the basis of emergency care costs.

299. We propose to include emergency care and maternity services in the cost base calculations for the same reasons we have proposed included them in the price setting method, as set out in Section 11.2.2.

11.7. Cost uplifts and adjustments

Proposal

We propose to set the inflation cost uplift factor at 3.8%.

As set out earlier in the document, we also propose:

- an adjustment in addition to the cost uplift factor of 1.25% to effect the proposed transfer of funding from CQUIN (see Section 11.6)
- an adjustment in addition to the cost uplift factor to reflect costs in relation to changes to product procurement arrangements (see Section 8).

11.7.1. About this proposal

Inflation cost uplift factor

300. To determine national prices for 2019/20 we need to assess cost pressures and calculate a cost uplift factor, which is used to adjust prices for expected changes to the major components of provider costs. This cost uplift factor is intended to reflect forward-looking cost changes deemed outside the control of providers in prospective national prices. For 2019/20 we also propose that the cost uplift factor applies to the calculation of the unit prices to be used in the new payment approach for emergency care and the non-mandatory prices for
maternity services, even though we propose that they will cease to be subject to national prices.

301. We gathered initial estimates across several cost categories and then reviewed them to set an appropriate figure for the tariff, which in some instances requires an adjustment to the initial figure. Table 7 outlines the cost categories and the source for initial estimates.

Table 7: Costs included in the cost uplift factor

<table>
<thead>
<tr>
<th>Cost category</th>
<th>Description</th>
<th>Source for initial estimates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pay</td>
<td>Assumed pay settlement, pay drift and other labour costs.</td>
<td>Department of Health and Social Care</td>
</tr>
<tr>
<td>Drugs</td>
<td>Expected changes in drug costs included in the tariff.</td>
<td>Department of Health and Social Care</td>
</tr>
<tr>
<td>Capital</td>
<td>Expected changes in the revenue consequences of capital.</td>
<td>Department of Health and Social Care</td>
</tr>
<tr>
<td>CNST</td>
<td>Expected changes in CNST contributions.</td>
<td>NHS Resolution</td>
</tr>
<tr>
<td>Other</td>
<td>General inflation for other operating expenses.</td>
<td>Office for Budgetary Responsibility</td>
</tr>
</tbody>
</table>

302. We propose to use broadly the same methodology for setting cost uplifts that we have used in previous years. We are making some adjustments to the initial estimates for capital and drug cost inflation, as explained below. We also propose some changes to the way in which costs are weighted in the final cost uplift factor.

303. To estimate the cost uplift factor for 2019/20, we propose to:

- forecast an appropriate rate of change for each of the categories in Table 7
- estimate cost weights for each category based on actual proportions in the 2017/18 consolidated accounts (based on costs relevant to tariff services)
- combine the estimates of change into a single cost uplift factor using the cost weights for each category.
304. Based on the approach we have developed for the cost uplift factor and the latest data available, we propose to use an uplift factor of 3.8% for 2019/20. A breakdown of this estimate, calculated using the approach described above, is shown in Table 8.

Table 8: Elements of inflation in the proposed 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>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%</td>
</tr>
</tbody>
</table>

Please note: pay includes the AfC pressure funded centrally in 2018/19 (2.1%), estimated 2019/20 AfC costs (3.4%), estimated medical pay award costs, including the full year effect of the 2018/19 pay award (3.1%) and incremental drift (0.1%). These figures are not cost-weighted and AfC is estimated at 75.20% of total pay costs. Excluding the 2018/19 AfC pay deal, the 3.8% cost uplift factor would be 2.8%.

305. For capital costs we propose to use the GDP deflator, as calculated by the Office for Budgetary Responsibility,\(^{36}\) to estimate the change in costs for 2019/20. We believe this is the most reliable estimate available.

306. For drug unit costs we propose to use the GDP deflator to estimate the change in costs for generic drugs and to assume that the change in costs for branded medicines will remain flat. This only relates to drugs costs included in the tariff, ie not high cost drugs that are funded separately.

307. For the cost weights, we propose to exclude costs that are not funded through the tariff, which includes high cost drugs and education and training. We also exclude costs that are a mix of different costs and to which a single estimate of

\(^{35}\) Note: calculations are done unrounded – only one decimal place displayed

\(^{36}\) We used the latest available GDP deflator for 2019/20, which was from November 2018: [www.gov.uk/government/collections/gdp-deflators-at-market-prices-and-money-gdp](http://www.gov.uk/government/collections/gdp-deflators-at-market-prices-and-money-gdp)
change is not possible, such as the purchasing of health from NHS and non-NHS providers.

Cost base (CQUIN) and changes to procurement arrangements

308. As set out earlier in the document, we also propose:

- an adjustment in addition to the cost uplift factor of 1.25% as a result of the proposed transfer of funding from CQUIN (see Section 11.6)
- an adjustment in addition to the cost uplift factor to reflect costs relating to changes to procurement arrangements (see Section 8).

309. Section 11.9 summarises all of the proposed cost adjustments.

11.7.2. Why we think this is the right thing to do

Inflation cost uplift factor

310. Every year the efficient cost of providing healthcare changes because of changes in wages, prices and other inputs over which providers have limited control. We therefore make a forward-looking adjustment to the modelled prices to reflect expected cost pressures in future years (the cost uplift factor).

311. Total pay cost change is estimated at 5.0% for 2019/20. This includes an estimate agreed with the Department of Health and Social Care (DHSC) for pay awards in 2019/20 and an estimate for pay drift. A one-off adjustment is also included to reflect funding for pay awards in 2018/19, which for AfC, was allocated to providers based on national modelling, rather than through tariff prices. The additional pension costs arising from changes to the discount rate are not included in the cost uplift factor.

312. Total drug cost change is estimated at 0.6% for 2019/20. This is calculated based on an assumption of unit costs for generic drugs increasing by the GDP deflator, which is a broad measure of inflation in the economy. The unit costs for branded medicines are assumed to be fixed, so the expected change is set at zero. These estimates are weighted based on the proportions of generic and branded medicine for tariff-included drugs, which calculates the final estimate.

313. This is a change to the initial estimate, due to uncertainty regarding the figure this produced. An initial estimate of expected expenditure growth for drugs

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This is a weighted estimate of pressures from both Agenda for Change and medical pay awards.
included in the tariff was considered, but this figure would need to be adjusted by a measure of activity to reflect a change in unit costs. In the 2017/19 NTPS, the GDP deflator was used as an estimate of change for the second year and we are proposing to use this approach again, but only for generic drugs included in the tariff. We believe the approach proposed for 2019/20 gives a reasonable estimate of drug pressures.

314. Total change in the revenue consequences of capital is estimated at 1.8% for 2019/20. This is based on the GDP deflator, as calculated by the OBR. This estimate of change would be assumed to apply for depreciation, private finance initiative (PFI) and public dividend capital (PDC).

315. This is a change to the initial estimate, which is due to uncertainty regarding the figure this produced. An initial estimate of expected expenditure growth for capital was considered, but this figure would need to be adjusted by a measure of activity to reflect a change in unit costs. In the last tariff, the expenditure growth estimate was used as an estimate of change but we do not propose to do this again, suggesting using the GDP deflator instead.

316. Total change in CNST, which is included in the tariff and cannot be allocated to HRG subchapters, is estimated at -1.0% for 2019/20. This is based on the change in estimated costs for 2018/19 (used in the 2017/19 NTPS) and the expected costs in 2019/20 (provided by NHS Resolution). The estimated change is negative due to an over-reimbursement of CNST costs in 2018/19, which has been addressed in-year, but for the purposes of the tariff needs to be adjusted downwards to align with the estimate of costs in 2019/20.

317. Total change in other operating costs is estimated at 1.8% for 2019/20. This is based on the GDP deflator, as calculated by the OBR. This estimate of change is assumed to apply to a wide range of costs not covered by the above categories.

318. We did consider an approach to the cost uplift factor that would set weights based on provider type, which might better reflect cost differences between acute and non-acute providers. We decided not to do so as this would result in different cost uplift factors for these services, which would be difficult to implement in practice. In addition, while it was clear that the use of aggregated cost weights could underestimate non-acute pay costs, it was less certain if a single measure of inflation overestimates these same costs. These
uncertainties are also driven by the uneven impact of the latest Agenda for Change (AfC) reforms across different providers. A single cost uplift factor is therefore proposed across all services.

319. However, we propose that for local price-setting, commissioners have due regard to the impact of the AfC reforms on actual cost inflation, where this can be shown to have a significant differential impact (for example on ambulance services).

320. For the same reasons that we propose to use the national prices calculation method for emergency care and maternity services (see Section 11.2.2), we propose to apply the cost uplift factor to these prices.

Cost base (CQUIN) and changes to procurement arrangements

321. We set out the rationale for the CQUIN cost base adjustment in Section 11.6 and for the adjustments for changes to procurement arrangements in Section 8.

11.8. Efficiency factor

Proposal

We propose to set the efficiency factor at 1.1% for 2019/20.

11.8.1. About this proposal

322. National prices are adjusted up by the cost uplift factor, reflecting our estimate of inflation, and down by the efficiency factor, reflecting our estimate of the average efficiency providers can be expected to achieve year-on-year. This approach is consistent with other sectors where prices are regulated centrally. For 2019/20 we propose that this adjustment also applies to prices for emergency care and maternity services, even though we are proposing that they are no longer national prices.

323. The efficiency factor reflects the cost reduction we expect providers to achieve by treating patients at lower cost over time, for example by introducing innovative healthcare pathways, technological changes or better use of the labour force.
324. The objective of the efficiency factor is to set a challenging but achievable target to encourage trusts to continually improve their use of resources, so that patients receive as much high-quality healthcare as possible. Our estimate of the level of efficiency that is stretching but achievable is based on evidence of the historical efficiency achieved by the sector.

325. Setting the efficiency factor inappropriately can have adverse impacts on providers, commissioners and patients because:

- setting an efficiency factor too high (prices too low) may challenge the financial position and sustainability of providers. Providers may not be adequately reimbursed for the services they provide, which could affect patients’ quality of care.
- setting an efficiency factor too low (prices too high) may reduce the volume of services that commissioners can purchase with given budgets affecting patients’ access to services. Setting prices above efficient costs may reduce the incentive for providers to achieve cost savings.

11.8.2. Why we think this is the right thing to do

326. Our recommendation is supported by NHS Improvement analysis of the nine-year efficiency trend in the sector, specifically of NHS acute providers.\(^{38}\) It is also based on a consideration of other relevant evidence, for example the financial position of the NHS provider sector and external estimates of NHS productivity.\(^{39}\)

327. The analysis is based on an econometric model of cost variations between providers over time explained by i) the outputs they produce and ii) factors outside their control. The remaining trend over time is interpreted as trend efficiency and residual differences between trusts are used to estimate the

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\(^{38}\) It is still not possible to extend the economic model to other sectors, such as ambulance, community and mental health, due to the availability of data. However, this should continue to be reviewed in future years with further external evidence considered.

\(^{39}\) For example:
   York, Centre for Health Economics -
   www.york.ac.uk/media/che/documents/papers/researchpapers/CHERP138_Hospital_Productivity_NHS.pdf
   Office for National Statistics -
distribution of efficiency across the sector.\textsuperscript{40} This model has been developed further in subsequent tariffs and more recent data has been incorporated each time.\textsuperscript{41}

328. For the 2019/20 NT\textsuperscript{PS}, we considered how we might develop the existing econometric model, as well as whether any update to the evidence was needed. We updated the analysis to include 2015/16 and 2016/17 data,\textsuperscript{42} which allows us to account for more recent changes to efficiency when setting the efficiency factor. We have also refined the measurement of disease prevalence in the model\textsuperscript{43} and conducted a range of additional sensitivity checks.

329. We estimated two measures of efficiency in this updated model: trend efficiency and variation in efficiency.

- Trend efficiency is the average sector-wide efficiency gain we observe over time. This could arise from new technologies, improved hospital processes or less efficient trusts catching up with more efficient ones. We estimate trend efficiency as a percentage reduction in costs over time that does not vary by trust. Given the importance of achieving value for money in the NHS, we consider that it is reasonable to set an efficiency ask at least at the level of historical trend efficiency.

- Variation in efficiency is the range of efficiency performance across trusts. This could arise from differences in use of technologies, or differences in hospital processes. We estimate variation in efficiency as a percentage difference in costs from the average trust that does not change over time. We use this to inform our understanding of what reasonable efficiency level, over and above trend efficiency, would enable less efficient trusts to catch up with more efficient trusts.

\textsuperscript{40} For a detailed description of the model, see the Deloitte report, \textit{Methodology for efficiency factor estimation}.

\textsuperscript{41} The report of the efficiency factor for the 2016/17 national tariff can be found here: \textit{Evidence on the efficiency factor}.

\textsuperscript{42} Where changes in data collections mean data is not available for variables, for instance certain diseases’ prevalence in the Quality and Outcomes Framework, we have extrapolated based on historical data.

\textsuperscript{43} Judgements are generally made on disease prevalence data due to breaks in the data. We established the following principles when doing so: 1) interpolation and extrapolation is used to include as much information on disease as possible; 2) diseases with data gaps of more than three years are excluded and 3) changes in data definitions are managed by applying growth rates of the new series to the old series.
330. Table 9 displays the results of the core estimate of our model and suggests it may be reasonable for the efficiency factor to be at least 0.9% with a catch-up factor to reduce variations in efficiency.

Table 9: Efficiency estimates

<table>
<thead>
<tr>
<th>Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trend efficiency</td>
</tr>
<tr>
<td>0.9%</td>
</tr>
<tr>
<td>Variation in efficiency</td>
</tr>
<tr>
<td>Median to 60th centile</td>
</tr>
<tr>
<td>Median to 70th centile</td>
</tr>
<tr>
<td>Median to 80th centile</td>
</tr>
<tr>
<td>Median to 90th centile</td>
</tr>
</tbody>
</table>

Notes: The econometric analysis is based on cost data from 168 providers for the period 2008/09-2016/17.

331. Our modelling suggests that trusts become 0.9% more efficient each year on average. Around this trend, we estimate that there is substantial variation in efficiency that could justify an efficiency factor greater than 0.9%. This is if poorer performers improved their efficiency at a greater rate. For instance, if the average performer catches up to the 60th centile we estimate that this would release 1.1% efficiency in addition to trend efficiency.

332. However, adjusting the time period of the model highlighted that the delivery of efficiencies has slowed in recent years.

333. We propose an efficiency factor of 1.1%, which we regard as challenging but achievable given the evidence around catch-up potential and trends in efficiency and financial pressure. It would also better align the efficiency ask in the tariff with the expectation on the health system, as part of the long-term funding settlement.

11.9. Summary of proposed cost adjustments

334. Table 10 summarises the adjustments proposed in Section 8, for centralised procurement, and Sections 11.6 to 11.8 (cost base, cost uplifts and efficiency).
335. We propose to change the wording of local pricing rule 2 to make clear that commissioners and providers should have regard to any adjustments set out in Section 4 of the draft 2019/20 NTPS when setting local prices for services without a national price.

336. We have provided the proposed adjustments by different service types to support local pricing in these areas. The adjustment for acute services would apply to services with national prices. The only difference we are proposing between services is for the differential effect of changes to procurement arrangements (see Section 8).

337. In relation to the adjustments for mental health, ambulance and community services (which are locally priced), the figures reflect the proposed adjustments to which commissioners and providers would have regard, pursuant to local pricing rule 2.

Table 10: Summary of proposed cost adjustments

<table>
<thead>
<tr>
<th></th>
<th>Acute/ nationally priced services</th>
<th>Mental health</th>
<th>Ambulance</th>
<th>Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost uplift factor</td>
<td>3.8%</td>
<td>3.8%</td>
<td>3.8%</td>
<td>3.8%</td>
</tr>
<tr>
<td>(before CQUIN and</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>procurement adjustments)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CQUIN</td>
<td>1.25%</td>
<td>1.25%</td>
<td>1.25%</td>
<td>1.25%</td>
</tr>
<tr>
<td>Procurement changes</td>
<td>-0.36%</td>
<td>-0.10%</td>
<td>-0.08%</td>
<td>-0.05%</td>
</tr>
<tr>
<td>Efficiency factor</td>
<td>-1.1%</td>
<td>-1.1%</td>
<td>-1.1%</td>
<td>-1.1%</td>
</tr>
<tr>
<td>Total proposed</td>
<td>3.6%</td>
<td>3.9%</td>
<td>3.9%</td>
<td>3.9%</td>
</tr>
<tr>
<td>adjustments</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please note: The pay element of the cost uplift factor includes the AfC pressure funded centrally in 2018/19 (2.1%), estimated 2019/20 AfC costs (3.4%), estimated medical pay award costs, including the full year effect of the 2018/19 pay award (3.1%) and incremental drift (0.1%). These figures are not cost-weighted and AfC is estimated at 75.20% of total pay costs. Excluding the 2018/19 AfC pay deal, the 3.8% cost uplift factor would be 2.8%.
12. National variations

338. National variations refer to variations to national prices specified in the national tariff (s116(4)(a) of the 2012 Act). They relate to circumstances where it is appropriate to make national variations to national prices (as distinct from local variations agreed between commissioners and providers). National variations may reflect certain features of costs that are not fully captured in national prices or seek to share risk more appropriately between providers and commissioners. The national variations in the 2017/19 NTPS aim to do one of the following:

- improve the extent to which prices reflect location-specific costs (eg MFF)
- improve the extent to which prices reflect patient complexity (eg top-ups for specialised services)
- create incentives to share responsibility for preventing avoidable unplanned hospital stays (eg the marginal rate emergency rule)
- share financial risk appropriately following (or during) a move to new payment approaches (eg national variation to support the implementation of the BPT for hip and knee replacements).

339. For 2019/20, we propose to:

- update the calculation method and data for the MFF – see Section 7
- remove the national variations relating to avoidable unplanned hospital stays (marginal rate emergency rule (MRET) and 30-day readmission rule) as part of the implementation of blended payment for emergency care – see Section 6
- remove reference to the transitional nature of the variation to support BPT for hip and knee replacements
- introduce a national variation for evidence-based interventions.

340. We propose to continue to the second step of the transition path for specialist top-up payment, following the move to prescribed specialised services (PSS) designation of specialist services. This means that the three services losing funding (orthopaedics, paediatrics and spinal surgery services) would receive 50% of the difference, rather than 75% in 2017/19.
12.1. Evidence-based interventions

Proposal

We propose to introduce a national variation that has the effect that if specified procedures are undertaken, they will not attract reimbursement without an individual funding request being approved.

12.1.1. About this proposal

341. As research is undertaken and medical advances are made, some interventions can be found to be inappropriate in specific circumstances. Sometimes, a safer, less invasive alternative will become available.

342. At both national and local levels, there is a general consensus that more needs to be done to ensure that interventions routinely available to people on the NHS are evidence based and clinically appropriate.

343. During the summer of 2018, NHS England ran a public consultation on proposals relating to 17 interventions. Four of these interventions were described as ‘Category 1’, meaning that they should be offered to patients on an exceptional basis and therefore be accompanied by an approved Individual Funding Request (IFR). The four interventions are:

- snoring surgery (in the absence of obstructive sleep apnoea (OSA))
- dilatation and curettage (D&C) for heavy menstrual bleeding (HMB) in women
- knee arthroscopy for patients with osteoarthritis
- injections for non-specific low back pain.

344. To support this, we propose to introduce a national variation into the NTPS which will have the effect that if the four procedures are undertaken, they will not attract reimbursement unless an IFR is made and approved. The proposed national variation would apply to all patients added to waiting lists after the publication of the statutory consultation on the 2019/20 NTPS, unless an IFR has been approved. The tariff change itself would apply from 1 April 2019.

---

12.1.2. Why we think this is the right thing to do

345. The NHS England consultation asked:

“Do you agree with our intention to mandate through the National Tariff by introducing arrangements so that providers should not be paid for delivering the four Category 1 interventions, unless a successful IFR is made?”

346. Responses were generally supportive, with 103 respondents agreeing with the intention and 46 not agreeing.

347. In the feedback to our October 2018 engagement, we also received broad support for making changes to the tariff to support the outcomes of the NHS England consultation.

Support for the proposal to add a national variation to the tariff to support the outcomes of NHS England’s consultation on evidence-based interventions

<table>
<thead>
<tr>
<th>Support for the proposal</th>
<th>Strongly support</th>
<th>Tend to support</th>
<th>Neither support or oppose</th>
<th>Tend to oppose</th>
<th>Strongly oppose</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
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<td>63</td>
<td>51</td>
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</tr>
<tr>
<td>%</td>
<td>22%</td>
<td>25%</td>
<td>21%</td>
<td>10%</td>
<td>14%</td>
<td>8%</td>
</tr>
</tbody>
</table>

348. We considered removing the relevant HRGs from the scope of national prices or doing nothing in the tariff. However, we felt that creating a national variation was the best way to use the tariff to support implementing the policy.

349. Commissioners and providers are expected to have implemented the clinical criteria for Category 1 interventions from 29 November 2018, following the publication of NHS England statutory guidance.45 We want to ensure that patients have access to the most appropriate interventions as soon as possible and to minimise avoidable harm to patients.

12.2. Top-up payments for specialised services

Proposal

We propose to:

- continue to use the University of York model, as in 2017/19, and the baseline of the PSS flags used in the 2017/19 NTPS.
- update the current prescribed specialised services (PSS) identification rules, hierarchy and provider eligibility lists.
- implement another 25% transition for the three services losing top-up funding as a result of the move to PSS and HRG4+.

12.2.1. About this proposal

350. Specialised services are accessed by comparatively few patients from a small number of providers with the right expertise. They are relatively expensive and account for around 14% of the total NHS budget. Top-up payments for specialised services were introduced in 2005 to reflect the extra costs of complexity.

351. For the 2017/19 NTPS, we had considered five methods to manage the change from basing top-ups on the Specialised Services National Definitions Set (SSNDS) to PSS definitions. The method that was chosen involved using the University of York model\(^{46}\) and updating it for changes in currency design, with a four-stage transition for the three services losing top-up funding: paediatrics, orthopaedics, and spinal cord injury services. There was an additional transition for spinal services, which received SSNDS top-up payments but would not otherwise receive PSS top-up payments. There was also a transition for services gaining funding through top-ups to ensure the overall transition did not change the amount of money that was allocated to top-ups.

352. For 2019/20 we have reviewed top-up payment rates and propose to update them to account for changes to the PSS identification rules, hierarchy changes and provider eligibility lists.\(^{47}\)

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\(^{46}\) [www.york.ac.uk/che/news/2015/che-research-paper-118/](http://www.york.ac.uk/che/news/2015/che-research-paper-118/)

353. We propose to move to the second stage of the transition path introduced in the 2017/19 NTPS following the move to PSS designation of specialist services. This means that the three services losing funding would receive 50% of the difference, rather than 75% in 2017/19.

12.2.2. Why we think this is the right thing to do

354. Our proposed updates reflect the most up-to-date definitions of PSS available and the HRG4+ currency design.

355. In agreeing the final policy proposal, we consulted and engaged widely with the sector as well as a number of different stakeholders including the National Casemix Office clinical EWG, the national tariff advisory group, HFMA, National Orthopaedic Alliance, a selected group of providers and NHS England Specialised Commissioning.

356. We also included a question on the proposed changes in our October survey on payment reform proposals. The feedback we received was broadly positive.

Support for the proposal to update specialist top-up rates

<table>
<thead>
<tr>
<th></th>
<th>Strongly support</th>
<th>Tend to support</th>
<th>Neither support or oppose</th>
<th>Tend to oppose</th>
<th>Strongly oppose</th>
<th>Don’t know</th>
</tr>
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<tbody>
<tr>
<td>Number</td>
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<td>14</td>
<td>13</td>
<td>31</td>
</tr>
<tr>
<td>%</td>
<td>9%</td>
<td>23%</td>
<td>43%</td>
<td>6%</td>
<td>6%</td>
<td>13%</td>
</tr>
</tbody>
</table>

357. We continue to believe that moving to the new top-up rates too quickly could destabilise providers and that it is appropriate to transition to the new levels.

358. We remain committed to exploring the reasons for cost variation in specialised and complex care.
13. Locally determined prices

359. Over half of the £76 billion of NHS activity covered by the national tariff is subject to local pricing arrangements.

360. Subject to compliance with local pricing rules and methods (see Section 6 of the NTPS), national prices can be adjusted to allow commissioners to innovate in the design of services for patients (local variations) or where they do not adequately reimburse efficient costs because of structural issues (local modifications). These changes must be published and, in the case of local modifications, NHS Improvement must agree to the proposals.

361. In setting local prices under the current rules, commissioners and providers must adhere to three principles:

- The approach must be in the best interests of patients.
- The approach must promote transparency to improve accountability and encourage the sharing of best practice.
- The provider and commissioner(s) must engage constructively with each other when trying to agree local payment approaches.

362. For 2019/20 we propose to introduce a new set of pricing rules for emergency care (see Section 7 of the draft 2019/20 NTPS) to implement in particular the proposed blended payment for that care (see Section 6). We also propose to adjust the wording of local pricing rule 2 to make clear that commissioners and providers should have regard to any cost adjustments set out in Section 4 of the draft 2019/20 NTPS when setting local prices for services without a national price (see Section 11.9).

363. We propose to make changes to the local pricing rules for mental health (rule 7) and high cost drugs, devices and listed procedures (rule 5).

364. We are not proposing any change to local pricing rule 10 (ambulance services). However, we have proposed changes to the guidance on emergency ambulance services (see Annex DTC – Currencies without a national price). These changes reflect the recommendation in Operational productivity and performance in English NHS ambulance trusts: unwarranted variations to support safe reductions 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.
365. For the 2019/20 NTPS, we are proposing to move the guidance on locally determined prices into Annex DtG. Commissioners would continue to have a duty to have regard to this guidance under the 2012 Act, Section 116(7).

13.1. Mental health services for adults and older people

Proposal

We propose to change local pricing rule 7 to mandate a blended payment approach for mental health services for working-age adults and older people. This would consist of a fixed element based on forecast activity, a variable element and an element linked to quality and outcomes measures and the delivery of access and wait standards. There would also be an optional risk share to promote collective management of financial risk.

13.1.1. About this proposal

366. We want our payment approach for mental health to:

- ensure providers are appropriately reimbursed for the services they deliver to people experiencing mental ill health
- ensure the payment for mental health supports the delivery of integrated care and policy objectives for integrated care systems (ICSs)
- improve the reporting, recording and costing of mental health activity for working age adults and older people.

367. We propose to amend local pricing rule 7 to make blended payments the default payment approach for adult mental health services. The blended payment approach for mental health would consist of:

- a fixed element based on forecast activity
- a variable element
- payment linked to quality and outcome measures and the delivery of access and wait standards
- an optional risk share agreement if providers and commissioners consider this appropriate locally.

368. The supporting document Guidance on blended payment for mental health services provides more details about the proposed approach. As the guidance
document explains, the proposed blended payment for mental health would not operate in exactly the same way as the blended payment for emergency care.

369. While blended payment would be the default, providers and commissioners would continue to be able to agree an alternative payment approach that better suits their local health economy needs, as long as it complied with relevant local pricing rules.

370. Mental health clusters remain the currencies that need to be used to submit activity data to NHS Digital’s Mental Health Services Data Set (MHSDS). We therefore propose that clusters are the basis for the blended payment approach. There is flexibility for providers and commissioners to agree alternative currencies as the basis for blended payments at a local level, where this complies with the relevant local pricing rules.

371. We propose to update Annex DtC to the NTPS (*National currencies without national prices*) to include mental health currencies. This would make it clearer that local pricing rules 3 and 4 apply to these currencies.

372. Rule 3 sets out that where a national currency is specified for a service, it must be used as the basis for local price setting, unless an alternative payment approach is agreed in accordance with rule 4. Rule 4 states that where a national currency is specified for a service, but the commissioner and provider of that service wish to move away from using it, the commissioner and provider may agree a price without using the national currency.

### 13.1.2. Why we think this is the right thing to do

373. In 2017, we undertook a formative evaluation of the choice of capitated or episodic payment approaches for mental health services that were introduced in the 2017/19 NTPS. We received a range of feedback, with the following key themes emerging. Respondents told us there was:

- limited local capacity to implement a new payment approach
- a lack of shared confidence in cost and activity data
- uncertainty about how capitated and episodic payment approaches would relate to operating models that would develop as part of integrated care systems.
374. During 2018, we continued to work with stakeholders to develop our proposals. This included holding workshops during the early summer to discuss our plans. We followed this up in August by sending a brief paper to stakeholders, setting out what was discussed in workshops and requesting more detailed feedback on our proposals. We also included proposed changes in our October engagement, where the responses were generally supportive.

Support for the proposal to introduce blended payment for emergency care

<table>
<thead>
<tr>
<th></th>
<th>Strongly support</th>
<th>Tend to support</th>
<th>Neither support or oppose</th>
<th>Tend to oppose</th>
<th>Strongly oppose</th>
<th>Don't know</th>
</tr>
</thead>
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<td><strong>Number</strong></td>
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<tr>
<td><strong>%</strong></td>
<td>5%</td>
<td>24%</td>
<td>37%</td>
<td>6%</td>
<td>7%</td>
<td>21%</td>
</tr>
</tbody>
</table>

375. During our discussions with stakeholders, we sought views on the following topics:

- How could the payment system best support the delivery of the Five Year Forward View for Mental Health?
- Should the amendment to local pricing rule 7 focus on blended payments only?
- How should care clusters be developed, including potentially mapping them against evidence-based care pathways?
- What might be appropriate alternative currency building blocks?
- What support could NHS England and NHS Improvement provide to help implement changes?

376. Overall there was strong feedback that moving to a blended payment approach would put mental health services in a stronger position, for example as ICSs develop.

377. Mental health clusters are the mandated currency to be used in developing blended payments. Including mandated mental health currencies in local pricing rules 3 and 4 would clarify the existing wording in the national tariff and would allow us to more systematically collect data on how commissioners and providers are implementing the payment approach in 2019/20.
13.2. Local pricing rule for high cost drugs, devices and listed procedures

Proposal

We propose that local pricing rule 5 is changed to allow a reference price to be used to support uptake of particular drugs.

13.2.1. About this proposal

378. The NTPS includes local pricing rules for the reimbursement of high cost drugs that are excluded from national tariff prices. Providers and commissioners must follow local pricing rules 5(c) and 5(e) when agreeing prices.

379. Rule 5(c) and 5(e) refer to the use of a national reference price, set by NHS England and based on the current best procured price for a product or group of products by the NHS.

380. The current local pricing rules mean that a reference price can only be used if it is lower than the actual cost to the provider or the nominated supply cost. However, this may act as a disincentive for providers to switch to biosimilar products at scale and pace.

381. We propose changing the local pricing rules so that reference prices could be set at a level that supports providers to switch towards the best value biosimilar medicines and forms the basis of local agreements between commissioners and providers.

382. We propose to amend local pricing rules 5(c) and 5(e) to read as follows:

**Rule 5(c):**

The price agreed should reflect:

(a) if there is a reference price for a drug specified as having been set at a level to incentivise provider uptake of the drug, that reference price; or

(b) if no such price is specified, the actual cost to the provider, or the nominated supply cost, or any reference price, whichever is lower.
Rule 5(e):

The ‘nominated supply cost’ is the cost which would be payable by the provider if the device or drug was supplied in accordance with a requirement to use a supplier or intermediary, or via a framework, specified by the commissioner, pursuant to a notice issued under SC 36.50 of the NHS Standard Contract (nominated supply arrangements). The reference prices are set by NHS England and are based on the current best procured price achieved for a product or group of products by the NHS, or set at a level to incentivise provider uptake of a particular drug.

13.2.2. Why we think this is the right thing to do

383. The biological medicines market is continuing to increase in complexity, with more biological medicines losing patent exclusivity and additional biosimilar medicines becoming available.

384. We want to support use of the best value clinically effective biosimilar medicines, ensuring it is embedded into commissioning and clinical practice. This will lay the foundations for successful adoption of other biosimilar medicines in the future, saving the NHS money that can then be reinvested into frontline services.

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48 A biosimilar medicine is a biological medicine that is developed to be highly similar and clinically equivalent to an existing biological medicine. A biosimilar contains a version of an active substance of an already approved biological medicine, which is referred to as the ‘reference medicine’ or ‘originator medicine’. Similarity to the reference medicine in terms of quality, structural characteristics, biological activity, safety and efficacy must be established based on a comprehensive scientific comparability exercise such that they do not have any clinically meaningful differences from the reference medicine in terms of quality, safety and efficacy. For more details, see: www.england.nhs.uk/medicines/biosimilar-medicines/
2019/20 National Tariff Payment System – A consultation notice (Part B)

Proposed 2019/20 National Tariff Payment System
Please note:

Part A of this document is the statutory consultation notice. It starts on page 5.

Part B of this document is the proposed 2019/20 National Tariff Payment System. This is shown as it would appear in final form. It starts on page 100

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1. **Introduction**

1. This document is the national tariff, specifying the currencies, national prices, the method for determining those prices, the local pricing and payment rules, the methods for determining local modifications and related guidance that make up the National Tariff Payment System for 2019 to 2020 (the 2019/20 NTPS).

2. Since 1 April 2016, Monitor and the NHS Trust Development Authority have operated as a single integrated organisation known as NHS Improvement. This document is published in exercise of functions conferred on Monitor by Section 116 of the Health and Social Care Act 2012. In this document, ‘NHS Improvement’ means Monitor, unless the context otherwise requires.

3. This 2019/20 NTPS has effect for the period beginning on 1 April 2019 and ending on 31 March 2020 or the day before the next national tariff published under Section 116 of the 2012 Act has effect, whichever is the later.¹

4. The document is split into seven sections:
   - the scope of the tariff
   - the currencies used to set national prices
   - the method for determining national prices
   - national variations to national prices
   - locally determined prices
   - rules for emergency care payments
   - payment rules.

5. There are also seven annexes, listed in Table 1.

### Table 1: 2019/20 NTPS annexes

<table>
<thead>
<tr>
<th>Annex</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>DtA</td>
<td>National tariff workbook (including national prices and prices to be used for emergency care)</td>
</tr>
<tr>
<td>DtB</td>
<td>Guidance on currencies with national prices</td>
</tr>
<tr>
<td>DtC</td>
<td>Guidance on currencies with no national price</td>
</tr>
</tbody>
</table>

¹ If a replacement national tariff was to be introduced before the end of the one-year period, this tariff would cease to have effect when that new tariff takes effect.
The national tariff is also supported by documents containing guidance and other information, listed in Table 2.

Table 2: Supporting guidance to the 2019/20 NTPS

<table>
<thead>
<tr>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>A guide to the market forces factor</td>
</tr>
<tr>
<td>Non-mandatory prices and currencies</td>
</tr>
<tr>
<td>Guidance on blended payment for emergency care</td>
</tr>
<tr>
<td>Guidance on blended payment for mental health services</td>
</tr>
<tr>
<td>Guidance on maternity payment pathway</td>
</tr>
</tbody>
</table>

All annexes and supporting materials can be downloaded from the NHS Improvement website.2

If you have any questions about the national tariff, please contact pricing@improvement.nhs.uk

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2. Scope of the 2019/20 NTPS

9. As set out in the Health and Social Care Act 2012, the national tariff covers the pricing of healthcare services provided for the purposes of the NHS. Subject to what we explain below, this covers all forms of NHS healthcare provided to individuals, whether relating to physical or mental health and whether commissioned by clinical commissioning groups (CCGs), NHS England or local authorities acting on behalf of NHS commissioners under partnership arrangements.

10. Various healthcare services are, however, outside the scope of the national tariff, as explained below.

2.1. Public health services

11. The national tariff does not apply to public health services:

- provided or commissioned by local authorities or Public Health England
- commissioned by NHS England under its Section 7A public health functions by agreement with the Secretary of State.

12. Public health services commissioned by local authorities include local open access sexual health services and universal health visitor reviews. The services commissioned by NHS England under Section 7A arrangements include public health screening programmes, sexual assault services and public health services for people in prisons.

2.2. Primary care services

13. The 2019/20 NTPS does not apply to primary care services (general practice, community pharmacy, general dental practice and community optometry) where payment is substantively determined by or in accordance with regulations or directions, and related instruments, made under the provisions of the National Health Service Act 2006 (‘the 2006 Act’).

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3 www.legislation.gov.uk/ukpga/2012/7/contents/enacted
4 See the meaning of ‘healthcare service’ given in Section 64 of the 2012 Act; and the exclusion of public health services in Section 116(11).
5 For the Section 7A agreement, see www.gov.uk/government/collections/nhs-public-health-functions-agreements.
6 See chapters 4 to 7 of the 2006 Act: for example, the Statement of Financial Entitlements for GP Services, and the drug tariff for pharmaceutical services.
14. Where the payment for NHS services provided in a primary care setting is not determined by or in accordance with regulations or directions, or related instruments, made under the 2006 Act then the 2019/20 NTPS rules on local price setting apply. For instance, local price-setting rules apply to minor surgical procedures performed by GPs and commissioned by CCGs. The rules governing payments for these services are set out in Section 6 Locally determined prices.

2.3. **Personal health budgets**

15. A personal health budget (PHB) is an amount of money to support the identified health and wellbeing needs of a particular patient, planned and agreed between that patient and their local NHS.

16. The three types of PHB are:

   - notional budget; no money changes hands – the patient and their NHS commissioner agree how to spend the money; the NHS will then arrange the agreed care
   - real budget held by a third party – an organisation legally independent of the patient and their NHS commissioner will hold the budget and pay for the care in the agreed care plan
   - direct payment for healthcare – the budget is transferred to the patient to buy the care that has been agreed between the patient and their NHS commissioner.

17. Payment to providers of NHS services from a notional budget is in the scope of the 2019/20 NTPS. It will be either governed by national prices as set out in Annex DtA (including national variations set out in Section 5) or subject to the local pricing rules (see Section 6.4).

18. In some cases, a notional budget may be used to buy integrated health and social care services to facilitate more personalised care planning. Where these services and products are not NHS services, the 2019/20 NTPS does not apply.

19. If a PHB takes the form of a direct payment to the patient or third-party budget, the payments for health and care services agreed in the care plan and funded from the direct payment are not in the scope of the 2019/20 NTPS. Direct
payments for healthcare are governed by regulations made under sections 12A(4) and 12B(1) to (4) of the 2006 Act.\(^7\)

20. The following are not in the scope of the 2019/20 NTPS, as they do not involve paying for provision of healthcare services:

- payment for assessing an individual’s needs to determine a PHB
- payment for advocacy – advice to individuals and their carers about how to use their PHB
- payment for the use of a third party to manage an individual’s PHB on their behalf.

21. More information about implementing PHBs can be found on the **NHS Personal Health Budgets page**.\(^8\)

### 2.4. Integrated health and social care

22. Section 75 of the 2006 Act provides for the delegation of a local authority’s health-related functions (statutory powers or duties) to its NHS partner, and vice versa, to help meet partnership objectives and create joint funding arrangements.

23. Where NHS healthcare services are commissioned under these arrangements (‘joint commissioning’), they remain in the scope of the 2019/20 NTPS even if commissioned by a local authority.

24. Payment to providers of NHS services that are jointly commissioned are governed either by a national price as set out in Annex D1A (including national variations set out in Section 5) where applicable, or by a local price (including a local variation in Section 6.2).

25. Local authority social care or public health services commissioned under joint commissioning arrangements are outside the scope of the 2019/20 NTPS.

### 2.5. Contractual incentives and sanctions

26. Commissioners’ application of Commissioning for Quality and Innovation (CQUIN) payments and contractual sanctions are based on provider

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\(^7\) See the National Health Service (Direct Payments) Regulations 2013 (SI 2013/1617, as amended) [http://www.legislation.gov.uk/uksi/2013/1617/contents/made](http://www.legislation.gov.uk/uksi/2013/1617/contents/made)

\(^8\) [http://www.england.nhs.uk/healthbudgets/](http://www.england.nhs.uk/healthbudgets/)
performance, after a provider’s income has been determined in accordance with the 2019/20 NTPS. If a contractual sanction changes the amount paid for the provision of an NHS service, this is permitted under the rules relating to the making of payments to providers under Section 7.

27. For 2019/20, the level of CQUIN payments has been reduced, from 2.5% to 1.25%. The funding made available by this reduction is being used to increase national and local prices (see Section 4.7.3 and local pricing rule 2).

2.6. Devolved administrations

28. The pricing provisions of the 2012 Act cover healthcare services in the NHS in England only. The devolved administrations (DAs) are responsible for the NHS in Scotland, Wales and Northern Ireland. If a patient from Scotland, Wales or Northern Ireland is treated in England or vice versa, the 2019/20 NTPS applies in some but not all circumstances.

29. Table 3 summarises how the 2019/20 NTPS applies to various cross-border scenarios. ‘DA commissioner’ or ‘DA provider’ refers to a commissioner or provider in Scotland, Wales and Northern Ireland.

Table 1: How the 2019/20 NTPS applies to devolved administrations

<table>
<thead>
<tr>
<th>Scenario</th>
<th>NTPS applies to provider</th>
<th>NTPS applies to commissioner</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>DA patient treated in England and paid for by commissioner in England</td>
<td>✓</td>
<td>✓</td>
<td>A Scottish patient attends A&amp;E in England</td>
</tr>
<tr>
<td>DA patient treated in England and paid for by DA commissioner</td>
<td>✗</td>
<td>✗</td>
<td>A Welsh patient, who is the responsibility of a local health board in Wales, has elective surgery in England which is commissioned and paid for by that local health board</td>
</tr>
<tr>
<td>English patient treated in DA and paid for by DA commissioner</td>
<td>✗</td>
<td>✗</td>
<td>An English patient, who is the responsibility of a CCG, attends A&amp;E in Scotland</td>
</tr>
<tr>
<td>Scenario</td>
<td>NTPS applies to provider</td>
<td>NTPS applies to commissioner</td>
<td>Examples</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>--------------------------</td>
<td>-------------------------------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>English patient treated in DA and paid for by commissioner in England</td>
<td>✗</td>
<td>✓</td>
<td>An English patient has surgery in Scotland which is commissioned and paid for by their CCG in England</td>
</tr>
</tbody>
</table>

30. In the final scenario above, the commissioner in England must follow the prices and rules in the 2019/20 NTPS, but there is no such requirement for the DA provider. The commissioner in England may wish or need to pay a price set locally in the country in question, or use a different currency from that mandated by the national tariff. In such cases, the commissioner must follow the rules for local pricing (see Section 6). If there is a national price for the service, a local variation would be required to pay a different price to the DA provider or to make a change to the currency. If there is no national price, the commissioner should follow the rules for local price setting.

31. Providers and commissioners should also be aware of guidance relating to cross-border payment responsibility. The England/Wales cross border healthcare services: statement of values and principles sets out the values and principles agreed between the NHS in Wales and the NHS in England to ensure smooth and efficient interaction between NHS organisations for patients along the England-Wales border. NHS England also provides comprehensive guidelines on payment responsibility in England.

32. The scope of the 2019/20 NTPS does not cover payment responsibility rules as set out in these documents. These rules should therefore be applied as well as any applicable provisions of the 2019/20 NTPS.

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10 [www.england.nhs.uk/who-pays/](www.england.nhs.uk/who-pays/)
3. **Currencies with national prices**

33. Currencies are one of the ‘building blocks’ that support the NTPS. They include the clinical grouping classification systems for which there are national prices in 2019/20.

34. Under the Health and Social Care Act 2012 (‘the 2012 Act’), the national tariff must specify certain NHS healthcare services for which a national price is payable.\(^{11}\) The healthcare services to be specified must be agreed between NHS England and NHS Improvement.\(^{12}\) The 2012 Act also provides that the national tariff may include rules for determining which currency applies where there is more than one currency and price for the same service.

35. We are using healthcare resource group HRG4+ phase 3 currency design as the basis for setting national prices for many services, including admitted patient care and outpatient procedures. We are also using HRG4+ as part of the new provisions for determining local prices for emergency care services (see Section 7). We are using the version of the currency design that was used for the collection of the 2016/17 reference costs.\(^{13}\)

36. This section should be read with the following information set out in:

- Annex DtA: National tariff workbook. This contains:
  - the list of national prices (and related currencies)
  - the lists of high cost drugs and devices
  - the list of emergency care unit prices (see the rules on emergency care in Section 7)
- Annex DtB: Guidance on currencies with national prices

3.1. **Classification, grouping and currency**

37. The NHS payment system relies on patient-level data. To operate effectively, the payment system needs:

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\(^{11}\) 2012 Act, Section 116(1)(a).

\(^{12}\) 2012 Act, Section 118(7).

• a way of capturing and classifying clinical activity: this enables information about patient diagnoses and healthcare interventions to be captured in a standard format

• a currency: the large number of codes for admitted patient activity in the primary classification system makes it impractical as a basis for payment; instead casemix groupings are used as the currency for admitted patients, outpatient procedures and A&E. For outpatient attendances, the currency is based on groupings that relate to clinical specialty and attendance type (eg first or follow-up attendance).

38. Clinical classification systems describe information from patient records with standardised definitions and nomenclature. The 2019/20 NTPS relies largely on two standard classifications to record clinical data for admitted patients. These are:

• the World Health Organization International Classification of Diseases, 10th revision (ICD-10) for diagnoses

• Office of Population Censuses and Surveys 5 (OPCS-5) for operations, procedures and interventions.

39. ‘Grouping’ is the process of using clinical information such as diagnosis codes (in admitted patient care only), procedure codes (in admitted patient care and outpatient care), treatment codes (A&E only) and investigation codes (A&E only) to classify patients to casemix groups structured around healthcare resource groups (HRGs). HRGs are groupings of clinically similar conditions or treatments that use similar levels of healthcare resources. The grouping is done using grouper software produced by NHS Digital. NHS Digital also publishes comprehensive documentation giving the logic and process behind the software’s derivation of HRGs as well as other materials that explain and support the development of the currencies that underpin the national tariff.

40. A ‘currency’ is a unit of healthcare for which a payment is made. Under the 2012 Act, a healthcare service for which a national price is payable must be specified in the national tariff. A currency can take many different forms; for

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14 The 5th edition update of ICD-10 was published in April 2015.
15 http://digital.nhs.uk/casemix/payment
16 Any enquiries on the ‘Code to grouper’ software, guidance and confirmation of appropriate coding and the grouping of activities can be sent to enquiries@nhsdigital.nhs.uk
example, it could involve a bundle of services for a group of patients or a particular population, or an individual episode of treatment.

41. We use spell-based\textsuperscript{17} HRGs as the currency for admitted patient care and some outpatient procedures.

42. The HRG currency design used for the 2019/20 NTPS is known as HRG4+ phase 3 and is arranged into chapters, each covering a group of similar conditions or treatments. Some chapters are divided into subchapters. The specific design for the 2019/20 NTPS is that used to collect 2016/17 reference costs.

43. The currency used for outpatient attendances is based on clinical specialty and attendance type, defined by treatment function code (TFC). This is explained in more detail in Section 3.2.4.

3.2. Currencies for which there are national prices

44. Section 3.2.1 describes the admitted patient care currencies for which there are national prices. These currencies and national prices no longer include maternity services and emergency care. From 2019/20, the prices for maternity services have been made non-mandatory and are subject to the local pricing rules specified in Section 6. Emergency care services are subject to the pricing rules specified in Section 7.

45. The methods we use to determine the national prices are set out in Section 4. The list of national prices and related currencies is in Annex DtD.

46. In particular circumstances we specify services in different ways, and attach different prices – for example, setting best practice tariffs (BPTs) to incentivise improved outcomes for particular cohorts of patients. As well as specifying the currencies, this section (in combination with Annexes DtA, DtB and DtD) includes the rules for determining which currencies and prices apply where a service is specified in more than one way.

47. The rules for the local pricing of services with national currencies but no national prices – such as adult mental health and ambulance services – are set out in Section 6.4. The rules for the local pricing of emergency care services,

\textsuperscript{17} A spell is a period from admission to discharge or death. A spell starts on admission of the patient.
which includes use of HRG4+ grouping for determining prices for those services, are set out in Section 7.

3.2.1. Admitted patient care

48. Spell-based HRG4+ phase 3 is the currency design for admitted patient care (excluding emergency care), covering the period from admission to discharge. If a patient is under the care of one consultant for their entire spell, this would comprise one finished consultant episode (FCE). Occasionally, a patient will be under the care of more than one consultant during their spell; this would mean that the spell had multiple FCEs.

49. National prices for admitted patient care cover the care received by a patient during their spell in hospital, including the costs of services such as diagnostic imaging. The national price to be applied is determined by the date of discharge.

50. The costs of some elements of the care pathway, such as critical care and high cost drugs, are excluded from national prices. These costs are paid under the rules applicable to local pricing.

51. To promote movement to day-case settings where appropriate, most elective prices are for the average of day-case and ordinary elective care costs, weighted according to the proportion of activity in each group.

52. For a few HRGs there is a single price across outpatient procedures and day cases, or a single price across all settings. This approach has been taken where a price that is independent of setting is clinically appropriate.

53. When a patient has more than one distinct admission on the same day\(^{18}\) (eg the patient is admitted in the morning, discharged, then readmitted in the afternoon), each admission is counted as the beginning of a separate spell.

54. Long stay payments\(^ {19}\) apply to admitted patient care. These are explained in detail below.

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\(^{18}\) Calendar day not 24-hour period.

\(^{19}\) For patients who remain in hospital beyond an expected length of stay for clinical reasons, there is an additional reimbursement to the national price called a ‘long-stay payment’ (sometimes referred to as an ‘excess bed day payment’). The long-stay payment applies at a daily rate to all HRGs where the length of stay of the spell exceeds a ‘trim point’ specific to the HRG.
55. Short stay emergency (SSEM) adjustments used to apply to national currencies and national prices for admitted patient care. However, SSEM adjustments are now incorporated within the new payment approach for emergency care (see Section 7).

Changes to the scope of services with national prices

56. The services for which there are national prices have changed from 2017/19 in the following ways:

- Maternity and emergency care services are no longer in the scope of national prices.
- Two HRGs and national prices for septic shock (WJ05A and WJ05B) have been withdrawn as NHS Digital’s coding guidance for sepsis published in December 2016 means it is not possible to record activity against these HRGs.
- Following clinical advice, new outpatient procedure prices have been introduced for:
  - EY13Z – Removal of Electrocardiography Loop Recorder
  - FF14Z – Adjustment of Gastric Band for Obesity
  - FE33Z – Therapeutic Flexible Sigmoidoscopy, 19 years and over
  - FE47Z – Combined Upper and Lower Gastrointestinal Tract Therapeutic Endoscopic Procedures
  - FE48B – Combined Upper and Lower Gastrointestinal Tract Diagnostic Endoscopic Procedures with Biopsy, 18 years and under.
- Outpatient procedure prices have been removed for:
  - BZ54B – Major, Orbit or Lacrimal Procedures, 19 years and over, with CC Score 0
  - EY12A – Implantation of Electrocardiography Loop Recorder with CC Score 3+.

57. While the tariff has been informed by the 2016/17 reference costs design of HRG4+ phase 3 and the 2016/17 reference cost relativities, the scope of the tariff, unless explicitly stated otherwise, is consistent with 2017/19.
Long-stay payment

58. A long-stay payment on a daily rate basis applies to all HRGs where the length of stay of the spell exceeds a specified trim point\(^{20}\) specific to the HRG and point of delivery.

59. The trim point is defined in the same way as for reference costs, but is spell based and there are separate elective and non-elective trim points. The trim point for each HRG is shown alongside national prices in Annex DtA.

60. For 2019/20, there is a trim point floor of five days.\(^{21}\) There are two long-stay payment rates per chapter – one for child-specific HRGs and one for all other HRGs.

61. If a patient is medically ready for discharge and delayed discharge payments have been imposed on local authorities under the provisions of the Community Care (Delayed Discharges etc) Act 2003, commissioners should not be liable for any further long-stay payment.

62. Long-stay payments may only be adjusted when SUS\(^{+}\)\(^{22}\) applies an adjustment for delayed discharge when the Discharge Ready Date field is submitted in the Commissioning Data Set, by removing the number of days between the ready date and actual discharge date from any long-stay payment. Where the Discharge Ready Date field is submitted, providers will wish to satisfy themselves that local authorities are being appropriately charged.

3.2.2. Chemotherapy and radiotherapy

Chemotherapy

63. HRG subchapter SB covers both the procurement and the delivery of chemotherapy regimens for patients of all ages. The HRGs in this subchapter are unbundled\(^ {23}\) and include activity undertaken in inpatient, day-case and non-admitted care settings.

\(^{20}\) The trim point is defined as the upper quartile length of stay for the HRG plus 1.5 times the inter-quartile range of length of stay.

\(^{21}\) For simplicity, we have shown a trim point floor of at least five days for all HRGs in the tariff spreadsheet, regardless of whether the HRG includes length of stay logic of less than five days.

\(^{22}\) https://digital.nhs.uk/services/secondary-uses-service-sus

\(^{23}\) HRG4 introduced unbundled HRGs, making it possible to separately report, cost and remunerate the different components within a care pathway.
64. Chemotherapy payment is split into three parts:

- a core HRG (covering the primary diagnosis or procedure) – this has a national price
- unbundled HRGs for chemotherapy drug procurement – these have local currencies and prices
- unbundled HRGs for chemotherapy delivery – these have national prices.

65. The regimen list can be accessed from NHS Digital.24

Radiotherapy

66. HRG subchapter SC covers both the preparation and the delivery of radiotherapy for patients of all ages. The HRGs in this subchapter are for the most part unbundled and include activity undertaken in inpatient, day-case and non-admitted care settings.

67. HRG4+ groups for radiotherapy include:

- radiotherapy planning for pre-treatment (planning) processes
- radiotherapy treatment (delivery per fraction) for treatment delivered, with a separate HRG allocated for each fraction delivered.

68. The radiotherapy planning HRGs are intended to cover all attendances needed to complete the planning process. It is not intended to record individual attendances for parts of this process separately.

69. The planning HRGs do not include the consultation at which the patient consents to radiotherapy, nor any medical review required by any change in status of the patient.

70. The HRGs for radiotherapy treatment cover the following elements of care:

- external beam radiotherapy preparation – this has a national price
- external beam radiotherapy delivery – this has a national price
- brachytherapy and molecular radiotherapy administration – this has local currencies and prices.

24 http://systems.digital.nhs.uk/data/clinicalcoding/codingstandards/opcs4/chemoregimens
71. Further information on the structure of the chemotherapy and radiotherapy HRGs and payment arrangements can be found in Annex DtB.

3.2.3. Nuclear medicine

72. Two new empty core HRGs for nuclear medicine were introduced in the 2016/17 reference cost currency design. They are RD97Z (diagnostic imaging) and RN97Z (nuclear medicine). Empty core HRGs allow a price to be paid for each scan. These two HRGs have a zero price in 2019/20 for outpatients. This is the same as for other current empty core HRGs.

3.2.4. Post-discharge rehabilitation

73. Post-discharge national currencies cover the entire pathway of treatment following discharge. They are designed to help reduce avoidable emergency readmissions and provide a service agreed by clinical experts to facilitate better post-discharge rehabilitation and reablement for patients.25

74. Post-discharge currencies cover four specific rehabilitation pathways:

- **Cardiac rehabilitation**
  The post-discharge price will only apply to the subset of patients identified as potentially benefitting from cardiac rehabilitation, where the evidence for the effect of cardiac rehabilitation is strongest; that is, those patients discharged having had an acute spell of care for:
  - acute myocardial infarction
  - percutaneous coronary intervention or heart failure
  - coronary artery bypass grafting.

- **Pulmonary rehabilitation**26
  The post-discharge price will apply to patients discharged having had an acute episode of care for COPD. The national price can be paid only for patients discharged from acute care with an HRG for the spell of care of DZ65A to DZ65K, who subsequently complete a course of pulmonary rehabilitation.

- **Hip replacement rehabilitation**
  The national price can only be paid for patients discharged from acute care

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25 More information on commissioning rehabilitation services can be found at: www.england.nhs.uk/ahp/improving-rehabilitation
26 Based on the care pathway outlined in the Department of Health and Social Care’s ‘Chronic Obstructive Pulmonary Disease (COPD) commissioning toolkit’.
with an episode of care with a spell dominant procedure of W371, W381, W391, W931, W941 or W951.

- **Knee replacement rehabilitation**
  The national price can be paid only for patients discharged from acute care with an episode of care with a spell dominant procedure coding of W401, W411, W421 or O181.

75. We are continuing with national prices for these four post-discharge currencies for the care of patients where a single provider provides both acute and community services. These prices are listed in Annex D1A. Where services are not integrated, the national price does not apply; however, we encourage the use of these prices in local negotiations on commissioning post-discharge care pathways.

76. Degrees of service integration vary. Accordingly, commissioners and providers will need to establish where both acute and community services are provided by a single provider to establish whether the post-discharge national prices should be used.

77. The post-discharge national prices must be paid on completion of a full rehabilitation pathway.

78. The post-discharge activity and national price will not be identified by the grouper or by SUS+. Therefore, in deriving a contract for this service, commissioners and providers need to agree locally the number of patients expected to complete rehabilitation packages. This forecast should be reconciled to the actual numbers of packages completed at year end.

79. Further information to support the implementation of all four post-discharge currencies, their scope and their specific rules can be found in Annex D1B.

### 3.2.5. Outpatient care

80. National prices for consultant-led outpatient attendances are based on clinic type, categorised according to treatment function code (TFC). There are

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27 TFCs are defined in the NHS Data Model and Dictionary as codes for ‘a division of clinical work based on main specialty, but incorporating approved sub-specialties and treatment interests used by lead care professionals including consultants’.
separate prices for first and follow-up attendances, for each TFC, as well as for single professional and multiprofessional clinics.  

81. To incentivise a change in the delivery of outpatient follow-up activity, to encourage a move to more efficient models and to free up consultant capacity, we over-reimburse first attendances and under-reimburse corresponding follow-up attendances. This transfer in cost (frontloading) is set at a TFC level and ranges from 0% to 30%. There is a full list in Annex DtA.

82. Following feedback, the frontloading in 2019/20 is reduced from 30% to 20% for ophthalmology (TFC 130), urology (TFC 101), and dermatology (TFC 330). Frontloading for nephrology (TFC 361) is reduced from 10% to 0%.

83. The outpatient attendance national price remains applicable only to pre-booked, consultant-led attendances and in accordance with the service conditions in the NHS Standard Contract.

84. When an attendance with a consultant from a different main specialty occurs during a patient’s admission and replaces an attendance that would otherwise have taken place, it should attract a national price provided it is pre-booked and consultant-led.

85. When a patient has multiple distinct pre-booked outpatient attendances on the same day (e.g. one attendance in the morning and a second separate attendance in the afternoon), each attendance is counted separately and will attract a separate national price unless a local pathway price has been agreed with commissioners.

86. Outpatient attendances do not have to take place on hospital premises. Therefore consultant-led outreach clinics held in a GP practice or a children’s centre should be eligible for the national price. For these clinics, it is important to make sure the data flows into SUS+ to support payment for this activity. However, home visits are not eligible for the outpatient care national price and are instead subject to local price setting.

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28 Multiprofessional attendances are defined as multiple care professionals (including consultants) seeing a patient together, in the same attendance, at the same time. For more detail see Annex DtB.

87. If, following an outpatient attendance, a patient attends an allied health professional (eg a physiotherapist), the costs of the latter attendance are not included in the national price for the original attendance and these attendances will be subject to local price setting (in accordance with the rules on local pricing).

88. Commissioners and providers should use the NHS Data Model and Dictionary to decide the category of outpatient attendance and day-case activity. Furthermore, providers must ensure that the way they charge for activity is consistent with the way they cost activity in reference costs, and consistent with any conditions for payment included in contracts.

89. For some procedures undertaken in an outpatient setting, there are national prices based on HRGs. If more than one of these procedures is undertaken in a single outpatient attendance, only one price is applicable. The grouper software will determine the appropriate HRG, and the provider will receive payment at the relevant price.

90. Where a procedure-driven HRG is generated, SUS+ determines whether the HRG has a mandatory national price and, if so, applies it. Outpatient procedures for which there is no national HRG price will be paid according to the relevant outpatient attendance national price.

91. For TFCs with no national price, the price should be set through local price-setting (in accordance with the rules on local pricing). The national price for any unbundled diagnostic imaging associated with the attendances must be used in all cases. National prices for diagnostic imaging in outpatients are mandatory, regardless of whether the core outpatient attendance activity has a national price.

92. Local systems are being encouraged to introduce advice and guidance services as part of plans to manage demand in secondary care acute services. To support this, we have set a non-mandatory price for advice and guidance services. See the supporting document Non-mandatory prices and currencies for details.

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30 The NHS Data Model and Dictionary Service sets out the definitions to be applied. It provides a reference point for assured information standards to support healthcare activities in the NHS in England.
Non-face-to-face activity

93. To further incentivise the use of new delivery models for follow-up appointments, increased use of non-face-to-face appointments or wider adoption of technology, we want to encourage providers and commissioners to agree local prices, at a TFC level, for non face-to-face activity.

94. For 2019/20 we have published non-mandatory prices for non-face-to-face and non-consultant-led activity. See the Non-mandatory prices and currencies workbook for details.

Outpatient pathways

95. The approach to the setting of outpatient follow-up prices does not preclude commissioners and providers agreeing local variations (in accordance with the rules for local variations) that reflect local pathways and/or National Institute for Health and Care Excellence (NICE) guidance, either within the acute setting or across acute and community settings. Examples of these could include specific pathways of care in dermatology or ophthalmology or cover pathways for patients with more complex needs that do not have a discrete TFC for identification and reimbursement. For more details on local variation, see Section 6.

3.2.6. Direct access

96. There are national prices for activity accessed directly from primary care, which are listed in Annex Dta. One example is where a GP sends a patient for a scan and results are sent to the GP for follow-up rather than such a service being requested as part of an outpatient referral.

97. The outpatient Commissioning Data Set version 6.2 has a field that can be used to identify services that have been accessed directly.\(^{31}\)

98. Where direct access activity is processed through the grouper, both a core HRG and an unbundled HRG will be created. When the activity is direct access, the core HRG should not attract any payment but the direct access service should attract a payment.

\(^{31}\)SUS R16 release (April 2016) has a requirement to add new functionality to implement the CDS6.2 new data item ‘Direct access indicator’.
99. In the case of direct access diagnostic imaging services for which there are national prices, the costs of reporting are included in prices. These costs are also shown separately in Annex DTA so that they can be used if a provider provides a report but does not carry out the scan.

100. There is also a non-mandatory price for direct access plain film X-rays.

3.2.7. Best practice tariffs

101. A best practice tariff (BPT) is usually a national price that is designed to incentivise quality and cost-effective care. For 2019/20, BPTs will also form part of the arrangements for determining prices for emergency care, under local pricing rules (see Section 7). The first BPTs were introduced in 2010/11 following Lord Darzi’s 2008 review.\(^\text{32}\)

102. The aim is to reduce unwarranted variation in clinical quality and spread best practice. BPTs may introduce an alternative currency to an HRG, including a description of activities that are associated with good patient outcomes. An incentive to move from usual care to best practice is created by creating a price differential between agreed best practice and usual care. More detail on the method for setting BPT prices can be found in Section 4.

103. Where a BPT introduces an alternative currency for a nationally priced service, that currency should be used in the cases described here, and set out in Annexes DTA, DTB and DTD.

104. Each BPT is different, tailored to the characteristics of clinical best practice for a patient condition and to the availability and quality of data. However, there are groups of BPTs that share similar objectives, such as:

- avoiding unnecessary admissions
- delivering care in appropriate settings
- promoting provider quality accreditation
- improving quality of care.

105. The service areas covered by BPTs are all:

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\(^{32}\) *High quality care for all*, presented to Parliament in June 2008.
• high impact (that is, high volumes, significant variation in practice, or significant impact on patient outcomes)
• supported by a strong evidence base and clinical consensus on what constitutes best practice.

106. Details of all BPTs and their eligibility criteria are provided in Annex DtD.

107. The 2019/20 NTPS introduces new BPTs for:

• emergency laparotomy
• spinal surgery.

108. There are also updates to eight existing BPTs:

• acute stroke
• day-case procedures
• early inflammatory arthritis
• major trauma
• paediatric diabetes
• paediatric epilepsy
• primary hip and knee replacement outcomes
• rapid colorectal diagnostic pathway (straight to test – STT).

109. We have retired the BPT for same-day emergency care with the introduction of the blended payment for emergency care. Implementation of BPTs that relate to emergency care should follow the relevant rules (see Section 7).

110. Some BPTs relate to specific HRGs (HRG-level), while others are more detailed and relate to a subset of activity in an HRG (sub-HRG). The BPTs that are set at a more detailed level are identified by ‘BPT flags’. For sub-HRG level BPTs, there will be other activity covered by the HRG that does not relate to the BPT activity and so a ‘conventional’ price is also published for these HRGs to reimburse the costs of the activity unrelated to the BPT. For more information relating to the BPT flags see Annex DtA.

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Please note: this treatment will always fall within activity covered by the blended payment for emergency care. As such, the BPT will not be attached to a national price; it will be applied as part of the emergency care rules (see Section 7).
111. Top-up payments for specialised services and long-stay payments apply to all the relevant BPTs. The short stay emergency adjustment (SSEM) may apply to BPTs that are in part or in whole related to emergency care, as part of the blended payment for emergency care (see Section 7).

112. Full details of all BPTs and guidance on implementation and eligibility criteria are available in Annex DtD. See also Section 7 for details of the operation of BPTs that are partly or wholly related to emergency care and therefore do not apply to national prices but to emergency care arrangements under local pricing rules.

3.2.8. Looked-after children health assessments

113. Looked-after children\textsuperscript{34} are one of the most vulnerable groups in society.

114. One-third of all looked-after children are placed with carers or in settings outside the originating local authority. These are referred to as ‘out-of-area’ placements.

115. When children are placed in care by local authorities, their responsible health commissioner has a statutory responsibility to commission an initial health assessment and conduct six-monthly or yearly reviews. When the child is placed out-of-area, the originating commissioner retains this responsibility, but the health assessment should be done by a provider in the local area to promote optimal care co-ordination for the child.

116. Usually, there are clear arrangements between commissioners and local providers for health assessments of looked-after children placed ‘in area’. However, arrangements for children placed out-of-area are variable, resulting in concerns about the quality and scope of assessments.

117. To address this variability in the arrangements for children placed out-of-area and to enable more timely assessments, a national currency was devised. A checklist for implementing the currency is included in Annex DtB.

118. National prices apply for children placed out-of-area (see the ‘Other national prices’ tab in Annex DtA). When a looked-after child is placed out-of-area\textsuperscript{34} the

\textsuperscript{34} The National Society for the Prevention of Cruelty to Children (NSPCC) website on Children in Care states: “A child who has been in the care of their local authority for more than 24 hours is known as a looked after child. Looked after children are also often referred to as children in care, a term which many children and young people prefer”.
responsible commissioner must commission providers in the receiving area to undertake the health assessments and pay them using the national price.

119. There is a non-mandatory currency but no national currencies or national prices for in-area health assessments for looked-after children. In setting prices, commissioners and providers must adhere to the relevant rules and principles for local pricing set out in Section 6. Non-mandatory prices are available for children placed in-area to support the development of local prices (see Non-mandatory prices and currencies workbook).

3.2.9. Pathway payments

120. Pathway payments are single payments that cover a bundle of services\(^ {35}\) which may be provided by several providers for an entire episode or whole pathway of care for a patient. They are designed to encourage better organisation and co-ordination of care across a pathway and among different healthcare providers. Improving the co-ordination of care, including across different care settings (e.g. primary, secondary, community services and social care), has the potential to improve patient outcomes by reducing complications and readmissions.

121. For 2019/20, there is one nationally priced pathway-based payment system, for patients with cystic fibrosis. Maternity services also use a pathway-based system, which is non-mandatory and covered by local pricing rules. See Section 6.4 for details of the local pricing rules and the supporting document Guidance on the maternity pathway payment for details.

Cystic fibrosis pathway payment

122. The cystic fibrosis (CF) pathway currency is a complexity-adjusted yearly banding system with seven bands of increasing complexity of patient need. The tariff relates to a year of care. The pathway does not distinguish between adults and children.

123. The pathway payments cover all treatment directly related to CF for a patient during the financial year. This includes:

\(^{35}\) Section 117 of the 2012 Act provides that a bundle of services may be specified as a single service (i.e. a currency) to which a national price applies, where those services together constitute a form of treatment.
• admitted patient care and outpatient attendances (whether delivered in a specialist centre or under shared network care arrangements)
• home care support, including home intravenous antibiotics supervised by the CF service, home visits by the multidisciplinary team to monitor a patient’s condition, eg management of totally implantable venous access devices (TIVADs), collection of mid-course aminoglycoside blood levels and general support for patient and carers
• intravenous antibiotics provided during inpatient spells
• annual review investigations.

124. The cystic fibrosis pathway currency was designed to support specialist cystic fibrosis multidisciplinary teams to provide care in a seamless, patient-centred manner, removing any incentives to hospitalise patients whose care can be well managed in the community and in their homes. Furthermore, it allows early intervention (following international guidelines) to prevent disease progression – for example, through the use of antipseudomonal inhaled/nebulised antibiotics and mucolytic therapy.

125. Further information is provided in Annex DtA.

3.3. **High cost drugs, devices and listed procedures**

126. Several high cost drugs, devices and listed procedures are not reimbursed through national prices; instead they are subject to local pricing in accordance with the rules set out in Section 6. The relevant drugs, devices and procedures can be found on the high cost lists in Annex DtA. If they are not on this list, and are part of a nationally priced treatment or service, then the cost of the drug, device or listed procedure is covered by the national price. High cost drugs are excluded either individually or as a group exclusion, as indicated in Annex DtA.

127. Where a provider or commissioner believes that the national price does not cover the cost of the drug or device, in addition to the other costs of treating the patient, a local variation can be agreed between provider and commissioner to facilitate an additional payment. This must be done in accordance with local pricing rules (see Section 6).

128. For the 2019/20 NTPS we have updated the list of drugs, devices and procedures.
129. We have used the same guiding principles as in previous years, with one change: for devices, we have expanded the principles to support procurement arrangements introduced by NHS England Specialised Commissioning.

130. We have also stated that consumables required uniquely for the deployment of listed devices should be subject to reimbursement outside national prices. Annex DtA gives the details and includes the full lists of drugs devices and procedures.

3.4. The innovation and technology tariff

131. In 2017/19 we introduced an innovation and technology tariff (ITT) with the aim of setting incentives to encourage the uptake and spread of innovative medical technologies that benefit patients.

132. Since the introduction of the ITT, further developments have taken place to the national approach to supporting the adoption of innovation, most notably the Innovation and Technology Payment (ITP).

133. For 2019/20, we are removing reference to reimbursement arrangements for the ITT in the NTPS, although prostatic urethral lift systems will continue to be recognised in national prices.

134. NHS England will announce further details and arrangements for the ITT and ITP in 2019/20 in due course.
4. Method for determining national prices

135. Our aim in setting prices is to support the highest quality patient care delivered in the most efficient way.

136. We use the following principles for setting national prices:

- Prices should reflect efficient costs. This means that the prices set should:
  - reflect the costs that a reasonably efficient provider ought to incur in supplying services at the quality expected by commissioners
  - not provide full reimbursement for inefficient providers.
- Prices should provide appropriate signals by:
  - giving commissioners the information needed to make the best use of their budgets and enabling them to make decisions about the mix of services that offer most value to the populations they serve
  - incentivising providers to reduce their unit costs by finding ways of working more efficiently
  - encouraging providers to change from one delivery model to another where commissioners want this and where it is more efficient and effective.

4.1. Overall approach

137. We have set national prices for 2019/20.

138. National prices for 2019/20 are modelled from the currency design set out in Section 3 of this document, with 2016/17 cost and activity data. The methodology for the tariff model for 2019/20 national prices closely follows the methodology previously used by the then Department of Health Payment by Results (PbR) team, up to 2013/14, and previous national tariffs, including the 2017/19 NTPS.\(^{36}\)

139. It was not always possible to replicate the PbR method exactly. However, for the 2014/15, 2015/16 and 2016/17 national tariffs, there were minimal changes, other than to reflect updates to currencies, cost uplifts, efficiency and manual adjustments. For the 2017/19 NTPS, we made some changes, including removing calculation steps that did not have any clearly identifiable policy

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\(^{36}\) For a description of the 2013/14 PbR method, please see [*Payment by results, step by step guide: calculating the 2013/14 national tariff.***](#)
intention (such as adjustments that appeared to be historic manual adjustments). Where we have significantly deviated from the method used for the 2017/19 NTPS, we have set out the changes in this document.

140. The most significant change in our methodology from the 2017/19 NTPS process is including maternity services and emergency care in price calculations and related adjustments. Despite these services ceasing to be covered by national prices, the costs and related data for them are used in the method described below. The resulting prices, while not national prices, should be used as the unit prices which underpin the emergency services payment approach (see Section 7) and the non-mandatory prices for maternity services (see the supporting document Non-mandatory prices and currencies).

141. The other main differences in our methodology from the 2017/19 NTPS process are:

- including the transfer of £1 billion from the Provider Sustainability Fund (PSF) into non-elective and A&E prices (despite them no longer being national prices, as explained above)
- strengthened qualitative review of price relativities by NHS Digital’s National Casemix Office’s clinical expert working groups (EWGs), including reviews of two sets of draft prices
- increased specificity in how total amounts of money are adjusted for changes in the scope of the tariff
- using the revised methodology for calculating market forces factor (MFF) values
- incorporating revisions to the prescribed specialised services (PSS) eligibility lists, rules and hierarchy.

142. We have also made changes to the manual adjustment process, including introducing a standardised approach to treating prices based on very small numbers of cases (see Section 4.4).

143. While the underlying methodology has remained similar to previous years, for 2019/20 we have rewritten the software infrastructure used to calculate the prices, creating the model in the SAS software package, rather than the mix of

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37 For details of these changes, see paragraphs 186-187 of the 2017/19 NTPS
38 This is done through a cash in/cash out process. Annex DtF includes a summary of the cash in/cash out adjustments.
SQL and Excel that was used previously. The SAS code for the model is available in Annex DtF.

144. We will continue working to improve the model for future tariffs.

145. The section below explains the method for setting prices and the changes that have been made for this year.

4.2. The method for setting prices

4.2.1. Modelling prices for 2019/20

146. When implementing the PbR method for the 2019/20 tariff year, we have, as in previous years, continued to make minor improvements to the calculation setting process. For example, in the process of rebuilding the tariff calculation model in SAS, we were able to increase the accuracy of the trim points used for a number of excess bed days.

147. We have aimed to replicate the PbR methodology as far as possible. This section sets out the main changes we have made to the PbR method.

148. The PbR method set prices in different ways for different care settings (or points of delivery – POD). This was mainly due to differences in the type of input data used and differences in assumptions and incentives.

149. We have therefore developed different modules for different care settings (or POD). This means that, for 2019/20, we are following the same approach as previous tariffs and using a suite of tariff modules (see Annex DtF).

150. The steps in our modelling approach for 2019/20 are:

• Determine price relativities (based on average unit costs), using cleaned 2016/17 reference costs and Hospital Episode Statistics (HES) data as key inputs to calculate average costs for each currency (eg HRG) (see Section 4.3).

• Adjust the prices calculated in the first step to an appropriate base year. As price relativities are based on 2016/17 reference costs, we adjust them to the current year (2018/19) before making any forward-looking adjustments. To do this we adjust the draft prices by applying the efficiency, inflation and Clinical Negligence Scheme for Trusts (CNST) adjustment factors for 2017/18 and 2018/19. At this point we also reduce all admitted patient care
prices by the same percentage (a top-slice) to be reallocated for top-up payments for specialised services (see Section 5.3.2).

- Apply manual adjustments to modelled prices, based on clinical advice, to reduce the number of instances where price relativities are implausible, illogical or distorted (see Section 4.4).

- Apply the first element of the cost base adjustment factors to prices to ensure prices reimburse a total amount of cost equal to the previous tariff (see Section 4.6).

- Use adjustment factors to increase or decrease the total amounts allocated to specific areas (clinical subchapters and/or POD), where appropriate, in line with agreed policy decisions or clinical advice. The amount allocated is draft prices multiplied by 2016/17 activity. These factors are applied using a new cash in/out approach (see Annex DtF). The changes are based on the percentage difference between the initial amounts allocated and the desired amounts by POD and/or subchapter, with the prices changed by the same percentage. Examples of these changes include:
  - the second element of the cost base adjustment, which is to increase non-elective and A&E prices for the £1 billion transferred from the PSF
  - continuing the agreed transition path to account for price volatility associated with the move to HRG4+ and the PSS in the 2017/19 NTPS (see Section 5.2)

- Apply the third element of the cost base adjustment, which is to reflect the transfer of funding from Commissioning for Quality and Innovation (CQUIN) (see Section 4.6). This is done at the same time as adjusting prices to proposed 2019/20 levels to reflect cost uplifts and adjustments (see Section 4.7) and an estimation of the level of efficiency that we expect providers to be able to achieve in 2019/20 (see Section 4.8).

### 4.2.2. Setting prices for best practice tariffs for 2019/20

151. For 2019/20, we have used the same method for setting BPTs that was used for 2017/19. This means, that as far as possible, we have applied a standard method of pricing BPTs. This involves:

- using the modelled price, without adjustments, as the starting point

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39 An example of an illogical relativity could be where the price for a more complex treatment is lower than the price for a less complex treatment without good reason.
• setting a fixed differential between the BPT and non-BPT price (either a percentage or absolute value)
• setting an expected compliance rate that would be used to determine final prices
• calculating the BPT and non-BPT price so that the BPT would not add to or reduce the total amount paid to providers at an aggregate level.

152. For 2019/20, we have changed the methodology used to calculate the day-case BPT so it aligns with this process.

153. As set out in Section 7, BPTs that relate to emergency care in part or in whole are included within the blended payment agreement. We have not changed the approach to calculating these BPT prices.

154. All BPT prices are included in Annex DtA. Details of the compliance rates and implementation of BPTs are available in Annex DtD.

4.2.3. Calculating outpatient attendance prices

155. We have continued with the approach used in 2017/19 of over-reimbursing first outpatient attendances (frontloading). For 2019/20 we have made the following changes to frontloading levels:

• nephrology – reduced from 10% to zero
• urology – reduced from 30% to 20%
• ophthalmology – reduced from 30% to 20%
• dermatology – reduced from 30% to 20%.

156. Annex DtA contains a full list of outpatient frontloading levels.

4.3. Managing model inputs

4.3.1. Overall approach

157. The two main data inputs used to generate prices for the 2019/20 NTPS are:

• costs – 2016/17 reference costs

40 See 2016/17 reference costs
158. We explain these two datasets in more detail in this section.

159. The reference costs dataset contains cost and activity data for many, but not all, healthcare service providers. The data is collected from all NHS trusts and foundation trusts and therefore covers most healthcare costs. We do not currently collect cost data from the independent sector.

160. The HES activity dataset contains the number of admitted patient care (APC) spells, outpatient appointments and A&E attendances in England from all providers of secondary care services to the NHS. It is mainly needed for the APC tariff calculation because the APC currencies are paid on a spell basis, while the activity data contained in the reference cost dataset are based on finished consultant episodes (FCEs).

161. We have used 2016/17 reference costs and 2016/17 activity data to model prices for the 2019/20 NTPS.

162. We have used 2016/17 patient-level cost data to augment the reference cost data in some places. For example, we use patient-level cost data to set ‘normative prices’ for a small number of orthopaedic HRGs. These prices are based on expected clinical practice, informed by a detailed review of reference cost and patient-level cost data for a random sample of 30 patients in each of 15 trusts for five common orthopaedic procedures.

Reference cost dataset used

163. We use 2016/17 reference cost data\(^41\) for the prices for the 2019/20 NTPS. We use this reference cost dataset because it is closely aligned with the currency design\(^42\) of the 2019/20 NTPS.

Reference cost data cleaning

164. One of our main objectives in setting prices is to reduce unexplained tariff price volatility.

165. We consider that using cleaned data (ie raw reference cost data with some implausible records removed) will, over time, reduce the number of illogical cost inputs (for example, fewer very low cost recordings for a particular service and

\(^{41}\) See 2016/17 reference costs

\(^{42}\) We have used the HRG4+ currency system (see Section 3 for further details).
fewer illogical relativities).\textsuperscript{43} This, in turn, should reduce the number of modelled prices that require manual adjustment and should therefore increase the reliability of the tariff. We believe this benefit outweighs the disadvantage of losing some data points as a result of the data cleaning process.

166. The data cleaning rules we have applied remain unchanged from the 2017/19 NTPS. The rules exclude:

- outliers from the raw reference cost dataset, detected using a statistical outlier test known as the Grubbs test (also known as the 'maximum normed residual test')
- providers that submitted reference costs more than 50% below the national average for more than 25% of HRGs and at the same time also submitted reference costs 50% higher than the national average for more than 25% of HRGs submitted
- providers that submitted reference costs containing more than 75% duplicate costs across HRGs and departments.

167. We merged data where prices would have been based on very small activity numbers (fewer than 50) unless we were advised otherwise by the EWGs. This was done to maintain stability of prices over time. A review of orthopaedic services found that most trusts have small numbers of cases with anomalous costs for the HRG to which they are allocated, and that these costs are often produced by data errors. Small activity numbers increase the likelihood that prices can be distorted by such errors.

168. We also merged data where illogical relativities were found – for example, where a more complex HRG had a lower cost than a less complex HRG.

169. For the prices in the 2019/20 NTPS, we only cleaned reference cost data for the APC module.

4.3.2. HES data inputs

170. In our modelling of the prices for the 2019/20 NTPS, we used 2016/17 HES data, grouped by NHS Improvement using the 2016/17 (HRG4+) payment grouper and the 2019/20 engagement grouper.

\textsuperscript{43} An illogical relativity is where the cost of performing a more complex procedure is lower than the cost of performing a less complex procedure (without good reason).
171. Using NHS Improvement grouping is a deviation from the 2013/14 PbR method, which used HES data grouped by NHS Digital. However, we use NHS Improvement grouping because:

- it allows us more flexibility in the timing of grouping the data
- NHS Digital uses patient-identifiable data for grouping, which cannot be shared with third parties (to protect patient confidentiality). NHS Improvement’s method does not use patient-identifiable data.

172. The NHS Improvement grouping method aims to follow, as closely as possible, the NHS Digital grouping method. Initial analysis indicates that the differences between the two grouping methods are very small.

4.4. Manual adjustments

173. The 2013/14 PbR method involved making some manual adjustments to the modelled prices. This was done to minimise the risk of setting implausible prices (eg prices that have illogical relativities) based on reference cost data of variable quality. We have broadly followed this approach for the 2019/20 NTPS.

174. For 2019/20 we introduced some improvements in the process of making manual adjustments to the price relativities generated by our model. With the NHS Digital Casemix Office, we agreed the following approach to initial manual adjustments on modelled prices before engaging with EWGs and the sector.

175. We applied manual adjustments where price relativities are likely to be affected by very low activity numbers that could result in less robust reference cost data. Specifically, we set prices to the weighted average of day-case/elective (DC/EL) and non-elective prices (NE) in any of the following scenarios:

- DC/EL activity is less than 50.
- NE activity is less than 50.
- DC/EL is less than 3% of DC/EL and NE total activity.
- NE is less than 3% of DC/EL and NE total activity.

176. For HRGs that have high cost devices excluded in national prices, we applied manual adjustments to exclude reference cost data above a set value,

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44 Please note: these changes were made before the transfer of £1 billion into non-elective prices (see Section 4.2).
suggested by NHS Digital Casemix Office to be highly likely to include the device cost. Where devices should be included in national prices, we applied manual adjustments to exclude costs below a set value that is likely to exclude the device cost.

177. We applied manual adjustments to exclude outlier costs for 12 HRGs where one provider’s costs, in our view, distorted the price relativities.

178. Where the relevant speciality’s outpatient attendance price was higher than the outpatient procedure price in the same TFC, we manually adjusted the latter based on the weighted relevant outpatient attendance first/follow-up price.

179. We subsequently engaged with representatives of medical colleges, associations and societies through their respective EWGs. This allowed us to sense check the first version of the draft prices. Prices were manually adjusted based on the comments received from the EWGs.

180. We accepted proposed adjustments to make prices more reflective of clinical resource requirements. Where manual adjustments increased the total amount allocated to a particular service, these were offset by reductions elsewhere in the HRG chapter or subchapter.

181. These adjustments and those described above based on low activity levels and implausible costs were included in draft price relativities used for a second round of engagements with EWGs. They were also published in October 2018 as part of our engagement on payment reform proposals.45

182. Following feedback on these price relativities, further manual adjustments were made to address illogical relativities. Adjustments were also made to ensure that key prices met clinical resource requirements.

4.5. Volatility

183. In the 2017/19 NTPS we introduced an adjustment to reduce the volatility from introducing the HRG4+ phase 3 currency design. This involved adjusting prices in some subchapters such that services recover 75% of the initial estimated loss. Tariff prices outside these subchapters have been top-sliced to pay for this revenue adjustment. For 2019/20, we have continued this adjustment but

45 https://improvement.nhs.uk/resources/201920-payment-reform-proposals/
changed the amount recovered to 50% of the initial estimated loss. Table 4 displays the adjustment factors.

**Table 4: Subchapters and uplift adjustments**

<table>
<thead>
<tr>
<th>Subchapter</th>
<th>Subchapter description</th>
<th>Uplift adjustment</th>
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</thead>
<tbody>
<tr>
<td>HC</td>
<td>Spinal Procedures and Disorders</td>
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<tr>
<td>HD</td>
<td>Musculoskeletal and Rheumatological Disorders</td>
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</tr>
<tr>
<td>HE</td>
<td>Orthopaedic Disorders</td>
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</tr>
<tr>
<td>HN</td>
<td>Orthopaedic Non-Trauma Procedures</td>
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<td>HT</td>
<td>Orthopaedic Trauma Procedures</td>
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</tr>
<tr>
<td>LD</td>
<td>Renal Dialysis for Chronic Kidney Disease</td>
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</tr>
<tr>
<td>PB</td>
<td>Neonatal Disorders</td>
<td>7.9%</td>
</tr>
<tr>
<td>SB</td>
<td>Chemotherapy</td>
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</tr>
<tr>
<td>SC</td>
<td>Radiotherapy</td>
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</tr>
<tr>
<td></td>
<td>All remaining chapters</td>
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</tbody>
</table>

4.6. **Cost base**

184. The cost base is the level of cost that the tariff will allow providers to recover before adjustments are made for cost uplifts and the efficiency factor is applied.

185. For 2019/20, we have maintained our historic method for setting the tariff cost base (ie to equalise the cost base to the cost base of the previous tariff, adjusted for activity and scope changes) with three important changes:

- An increase in the cost base of around 1.25%, reflecting an equivalent reduction in CQUIN funding.
- The cost base and related adjustments no longer apply solely to nationally priced services but also to maternity and emergency care services, even though they are outside the scope of national prices.
- A £1 billion increase in the cost base to reflect an equivalent reduction in the PSF. This increase is only applied to A&E and non-elective prices.
186. As with many other parts of tariff setting, we use the previous year’s tariff as a starting point for the following tariff. Therefore, 2018/19 prices and revenue are used as a starting point.

187. After setting the starting point, we consider new information and several factors to form a view whether an adjustment to the cost base is warranted.

188. Information and factors that we considered include:

- historical efficiency and cost uplift assumptions
- latest cost data
- additional funding outside the national tariff
- changes to the scope of the national tariff, specifically for emergency care and maternity
- any other additional revenue that providers use to pay for tariff services
- our pricing principles and the factors that legislation requires us to consider, including matters such as the importance of promoting provision of healthcare services which is economic, efficient and effective and the need to consider the duties of commissioners (in the context of the budget available for the NHS).

189. In judging where to set the cost base, we consider the effect of setting the cost base too high or too low. This effect is asymmetric:

- If we set the cost base too low (ie we set too high an expectation that providers will be able to catch up to past undelivered efficiency), providers would be at greater risk of deficit, service quality could decrease below the level that would otherwise apply (eg increased emergency waiting times), and some providers might cease providing certain services.
- However, if we set the cost base too high, commissioners, who have an obligation to stay within their budgets, are likely to restrict the volumes of commissioned services, and could cease commissioning certain services entirely. This would reduce access to healthcare services.

190. For 2019/20, it is our judgement that it is appropriate to keep the cost base equal to the revenue that would be received under 2018/19 prices (adjusted for activity and scope changes), with the following changes:
• An increase in the cost base of around 1.25% to reflect the equivalent amount reallocated from CQUIN. We propose to apply this amount to all prices (both locally and nationally priced services) by making an adjustment in addition to the cost uplift factor in the tariff.\textsuperscript{46}

• To continue to include emergency care and maternity services within the scope of the cost base, even though they will no longer be subject to national prices.

• £1 billion transferred from the PSF, applied only to prices for emergency care.\textsuperscript{47}

4.7. Cost uplifts and adjustments

191. The cost uplifts in the 19/20 NTPS consist of four separate adjustments:

• inflation (including pay, drugs and capital costs and CNST contributions)
• service development
• cost base adjustment for CQUIN (see 4.6)
• centralised procurement.

4.7.1. Inflation

192. Every year, the efficient cost of providing healthcare changes because of changes in wages, prices and other inputs over which providers have limited control. We therefore make a forward-looking adjustment to the modelled prices to reflect expected cost changes in future years deemed outside providers’ control. We refer to this as the cost uplift.

193. We have retained broadly the same methodology for 2019/20 as for 2017/19 with some developments, as set out below.

194. In determining the inflation cost uplift adjustments, we considered six categories of cost pressures. These are:

• pay costs
• drugs costs
• other operating costs

\textsuperscript{46} This is an adjustment to the tariff cost base, as funding is moving into national prices from outside the NTPS. However, the cost uplift factor is being used to make the adjustment in the tariff. This enables it to be applied to local prices, in line with local pricing rule 2.

\textsuperscript{47} The £1 billion transfer from the PSF has been applied to non-elective prices, not including excess bed days. This avoids elective prices increasing as a result.
• changes in the cost associated with CNST payments
• revenue consequences of capital costs (ie changes in costs associated with depreciation and private finance initiative payments)
• costs arising from new requirements in the mandate to NHS England. We call these changes ‘service development’ costs. There are no adjustments from the mandate for service development in 2019/20.

195. The final cost uplift figure for operating costs also includes a specific adjustment in relation to changes to product procurement arrangements (see Section 4.7.4).

196. We gathered initial estimates across these cost categories and then reviewed them to set an appropriate figure for the tariff, which in some instances requires an adjustment to the initial figure. The adjustments are included in a total cost uplift factor that is then applied to the modelled prices.

197. In setting the general cost uplift factor, each cost category is assigned a weight reflecting the proportion of total expenditure. These weights are based on aggregate provider expenditure obtained from DHSC’s published 2017/18 financial accounts. Table 5 shows the weights applied to each cost category.

<table>
<thead>
<tr>
<th>Table 5: Elements of inflation in the proposed cost uplift factor</th>
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<tbody>
<tr>
<td><strong>Cost</strong></td>
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<tr>
<td>---------</td>
</tr>
<tr>
<td>Pay</td>
</tr>
<tr>
<td>Drugs</td>
</tr>
<tr>
<td>Capital</td>
</tr>
<tr>
<td>CNST</td>
</tr>
<tr>
<td>Other</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

Please note: pay includes the AfC pressure funded centrally in 2018/19 (2.1%), estimated 2019/20 AfC costs (3.4%), estimated medical pay award costs, including the full year effect of the 2018/19 pay award (3.1%) and incremental drift (0.1%). These figures are not cost-weighted and AfC is estimated at 75.20% of total pay costs. Excluding the 2018/19 AfC pay deal, the 3.8% cost uplift factor would be 2.8%.

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48 Note: calculations are done unrounded – only one decimal place displayed
198. The following costs are excluded from the calculation of cost weights:

- purchase of healthcare from other bodies, which includes a combination of costs and cannot be discretely applied to one specific category.
- education and training, which are not included in the national tariff and are instead funded by Health Education England.
- high-cost drugs, which are not included in the national tariff and are instead funded by NHS England.

199. Below, we describe our method for estimating the level of each inflation-related cost uplift component and the CNST adjustments. Section 4.9 summarises all cost adjustments.

**Pay**

200. As shown in Table 5, pay costs are a major component of providers’ aggregate input costs, so it is important that we reflect changes in these costs as accurately as possible when setting national prices.

201. Pay-related inflation has three elements. These are:

- pay settlements – the increase in the unit cost of labour reflected in pay awards for the NHS
- pay drift – the tendency for staff to move to a higher increment or to be upgraded; this also includes the impact of overtime
- extra overhead labour costs – there are no changes made for this in 2019/20. The additional pension costs arising from changes to the discount rate are not included in the cost uplift.

202. We use estimates based on DHSC’s central estimates for these components. DHSC maintains accurate and detailed records of labour costs in the NHS and is directly involved in pay negotiations. We assume pay drift and group mix effects of 0.1% in 2019/20.

203. New pay settlements were introduced for both Agenda for Change (AfC) and medical staff in 2018/19 and these will increase pay further in 2019/20. Additional costs for 2018/19 were funded directly with providers and these will be brought into the NTPS in 2019/20 through the cost uplift:
• AfC pay settlements are estimated to increase by 2.1% in 2018/19 (above 1% already included in the NTPS) and by 3.4% in 2019/20
• non-AfC pay settlements are estimated to increase by 1.1% in 2018/19 (above 1% already included in the NTPS) and by 2.0% in 2019/20.

204. The combined estimated impact of pay settlements and drift to be included in the cost uplift for 2019/20 is therefore 5.6% for AfC and 3.2% for non-AfC. These figures are weighted by the proportions of each to total pay costs.

205. In total, the projection is an increase in the pay bill of 5.0% in 2019/20.

206. For local price-setting, commissioners should have due regard to the impact of the AfC reforms on actual cost inflation, where this can be shown to have a significant differential impact (for example on ambulance services).

Drugs costs

207. The drugs cost uplift is intended to reflect increases in drugs expenditure per unit of activity. There are notable challenges in estimating this change and we have changed the methodology used in 2019/20.

208. Estimates of drug inflation describe the expected change in total drug expenditure, and adjustments are needed to include these in our calculation of tariff inflation. The first is to remove the increase in costs resulting from activity, which will be funded through an increase in volumes and therefore payments. The second adjustment is to exclude the impact of the more rapid forecast of price growth in high cost drugs paid for on a pass-through basis outside of tariff. Both adjustments can cause uncertainty in a final estimate.

209. NHS Improvement analysis on secondary care spend and unit product prices has not resulted in a final figure that we are confident best estimates changes in costs for 2019/20. We have therefore used the GDP deflator49 to estimate price growth in generic drugs included in the tariff and an assumption that price growth for branded medicines will remain flat for tariff purposes.

210. This results in assumed drugs cost inflation of 0.6% in 2019/20.

Other operating costs

211. Other operating costs include general costs such as medical, surgical and laboratory equipment and fuel. For this category of cost uplift, we have used the forecast of the GDP deflator estimated by the Office for Budget Responsibility (OBR) as the basis of the expected increase in costs. The GDP deflator, from November 2018,\(^{50}\) is 1.8% in 2019/20.

212. We are also making a further adjustment to the cost uplift factor in relation to changes to product procurement arrangements (see Section 4.7.4).

Clinical Negligence Scheme for Trusts

213. The CNST is an indemnity scheme for clinical negligence claims. Providers contribute to the scheme to cover the legal and compensatory costs of clinical negligence.\(^{51}\) NHS Resolution administers the scheme and sets the contribution that each provider must make to ensure the scheme is fully funded each year.

214. We have allocated the change in CNST costs to core HRG subchapters, to the maternity delivery tariff and A&E services, in line with the average cost increases that will be paid by providers. This approach is different to other cost adjustments, which are estimated and applied across all prices. Each relevant HRG is adjusted based on the change in CNST cost across specialties mapped to HRG subchapters. This means that our cost adjustments reflect, on average, each provider’s relative exposure to CNST cost changes, given their individual mix of services and procedures.\(^{52}\) In 2019/20, CNST adjustments are not only applied to national prices – they are also applied to maternity and emergency care prices.

215. Figure 1 sets out our approach to including CNST in the national tariff.


\(^{51}\) CCGs and NHS England are also members of the CNST scheme.

\(^{52}\) For example, maternity services have been a major driver of CNST costs in recent years. For this reason, a provider delivering maternity services as a large proportion of its overall service mix would probably find that its CNST contributions (set by NHS Resolution) have increased more quickly than the contributions of other providers. However, the cost uplift reflects this, since the CNST uplift is higher for maternity services. This is consistent with the approach previously taken by DHSC.
216. A provider’s CNST contributions are included in its reference costs. For the 2019/20 tariff, these are 2016/17 reference costs. The cost uplift, CNST and efficiency factors for 2017/18 and 2018/19 are then applied, as part of the process of bringing prices up to the cost base for the current year (ie the level of the year in which the prices are set). Cost base adjustments are then made to scale prices to the agreed payment levels (as set out earlier in this section) before applying the prospective CNST adjustment and the inflation and efficiency adjustments for the tariff year. The prospective adjustment is the difference between the total amount of CNST included in 2018/19 national prices (in the 2017/19 NTPS) and the total amount of CNST included in 2019/20 national prices and in the prices for maternity and emergency care services.

217. As the prices for 2018/19 were set in 2016/17, the amount included in national prices for CNST in 2018/19 was an estimate. The actual total of providers’ CNST contributions to NHS Resolution was lower than estimated. This means that national prices in 2018/19 were set higher than they would have been if the actual contributions had been used.

218. Because of the overestimation of CNST in 2018/19, and a reduction in the total of providers’ contributions in 2019/20, there is a reduction in national prices and prices for maternity and emergency services of £330 million.

219. Table 6 lists the percentage changes that we have applied to each HRG subchapter to reflect the change in CNST costs.

220. Most of the changes in CNST costs are allocated at HRG subchapter level, maternity or A&E, but a small residual amount (about £23.7 million in 2019/20) is unallocated at a specific HRG level. This unallocated figure is redistributed as a general adjustment across all prices. We have calculated the adjustment due to this pressure as -0.03% in 2019/20 (though this is given as 0.0% in Table 6 due to rounding).
### Table 6: CNST tariff impact by HRG subchapter

<table>
<thead>
<tr>
<th>HRG sub chapter</th>
<th>2019/20 uplift (%)</th>
<th>HRG sub chapter</th>
<th>2019/20 uplift (%)</th>
<th>HRG sub chapter</th>
<th>2019/20 uplift (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>AA</td>
<td>-0.47%</td>
<td>JA</td>
<td>-1.38%</td>
<td>PP</td>
<td>-1.46%</td>
</tr>
<tr>
<td>AB</td>
<td>-0.50%</td>
<td>JC</td>
<td>-0.67%</td>
<td>PQ</td>
<td>-0.57%</td>
</tr>
<tr>
<td>BZ</td>
<td>-0.70%</td>
<td>JD</td>
<td>-0.27%</td>
<td>PR</td>
<td>-1.23%</td>
</tr>
<tr>
<td>CA</td>
<td>-0.43%</td>
<td>KA</td>
<td>-0.62%</td>
<td>PV</td>
<td>-1.33%</td>
</tr>
<tr>
<td>CB</td>
<td>-0.29%</td>
<td>KB</td>
<td>0.05%</td>
<td>PW</td>
<td>-1.58%</td>
</tr>
<tr>
<td>CD</td>
<td>-0.18%</td>
<td>KC</td>
<td>-0.02%</td>
<td>PX</td>
<td>-1.31%</td>
</tr>
<tr>
<td>DZ</td>
<td>-0.04%</td>
<td>LA</td>
<td>-0.06%</td>
<td>SA</td>
<td>-0.25%</td>
</tr>
<tr>
<td>EB</td>
<td>-0.11%</td>
<td>LB</td>
<td>-0.44%</td>
<td>VA</td>
<td>-1.05%</td>
</tr>
<tr>
<td>EC</td>
<td>-0.14%</td>
<td>MA</td>
<td>-0.39%</td>
<td>WH</td>
<td>-0.43%</td>
</tr>
<tr>
<td>ED</td>
<td>-0.32%</td>
<td>MB</td>
<td>-0.56%</td>
<td>WJ</td>
<td>-0.08%</td>
</tr>
<tr>
<td>EY</td>
<td>-0.28%</td>
<td>PB</td>
<td>-1.19%</td>
<td>YA</td>
<td>-0.65%</td>
</tr>
<tr>
<td>FD</td>
<td>-0.56%</td>
<td>PC</td>
<td>-1.41%</td>
<td>YD</td>
<td>-0.14%</td>
</tr>
<tr>
<td>FE</td>
<td>-0.36%</td>
<td>PD</td>
<td>-1.52%</td>
<td>YF</td>
<td>-0.87%</td>
</tr>
<tr>
<td>FF</td>
<td>-1.21%</td>
<td>PE</td>
<td>-0.58%</td>
<td>YG</td>
<td>-0.25%</td>
</tr>
<tr>
<td>GA</td>
<td>-0.98%</td>
<td>PF</td>
<td>-1.34%</td>
<td>YH</td>
<td>-1.22%</td>
</tr>
<tr>
<td>GB</td>
<td>-0.28%</td>
<td>PG</td>
<td>-1.01%</td>
<td>YJ</td>
<td>-1.31%</td>
</tr>
<tr>
<td>GC</td>
<td>-0.59%</td>
<td>PH</td>
<td>-1.10%</td>
<td>YL</td>
<td>-0.22%</td>
</tr>
<tr>
<td>HC</td>
<td>-1.00%</td>
<td>PJ</td>
<td>-1.44%</td>
<td>YQ</td>
<td>0.08%</td>
</tr>
<tr>
<td>HD</td>
<td>-0.52%</td>
<td>PK</td>
<td>-0.96%</td>
<td>YR</td>
<td>-0.10%</td>
</tr>
<tr>
<td>HE</td>
<td>-1.97%</td>
<td>PL</td>
<td>-0.96%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HN</td>
<td>-1.25%</td>
<td>PM</td>
<td>-0.26%</td>
<td>VB</td>
<td>-1.09%</td>
</tr>
<tr>
<td>HT</td>
<td>-1.38%</td>
<td>PN</td>
<td>-0.77%</td>
<td>Maternity</td>
<td>-7.01%</td>
</tr>
</tbody>
</table>

Source: NHS Resolution. Note: Maternity is delivery element only
Capital costs (changes in depreciation and private finance initiative payments)

221. Providers’ costs typically include depreciation charges and private finance initiative (PFI) payments. As with increases in operating costs, providers should have an opportunity to recover an increase in these capital costs.

222. In previous years, we used DHSC estimates of capital expenditure growth when calculating cost uplifts. This meant increases in capital expenditure per unit of activity were not sufficiently captured without an appropriate adjustment for activity. For 2019/20, we have used an alternative methodology that uses the November 2018 GDP deflator as a broad measure of inflation in the economy.

223. This results in assumed capital cost inflation of 1.8% in 2019/20.

4.7.2. Service development

224. The service development uplift factor reflects the expected extra unit costs to providers of major initiatives that are included in the Mandate. There are no major initiatives anticipated in the Mandate to be funded through national prices in 2019/20, and no uplift is to be applied.

4.7.3. CQUIN

225. As set out in Section 4.6, we have increased the cost base by around 1.25% as a result of funding transferred from CQUIN. This is effected through a 1.25% increase in the cost uplift factor.

4.7.4. Changes to product procurement arrangements

226. To address the recommendations on unwarranted variations, as described in Lord Carter’s review of NHS operational productivity, DHSC has restructured the NHS Supply Chain operating model. This has involved the establishment of Supply Chain Coordination Limited (SCCL). The aim of the new model is to increase NHS purchasing power, give providers access to lower procurement prices and drive efficiencies through product rationalisation. To help achieve this, SCCL’s overhead costs (estimated to be around £253 million in 2019/20), will mostly be funded directly. This will enable the removal of mark-ups on

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54 The mandate to NHS England sets out objectives for the NHS and highlights the areas of healthcare where the government expects to see improvements.
product prices for providers of tariff services and consequently reduce the direct cost to those providers of procuring supplies from SCCL.

227. To reflect the new funding arrangements for SCCL and the reduced costs to providers, we are adjusting prices under the national tariff. This involves removing around £204 million from the total amount reimbursed through the national tariff. Our adjustment is intended only to cover costs relating to services covered by the NTPS and not those that are covered by other SCCL income streams (such as rebates from suppliers and income from customers not providing tariff services).

228. The adjustment to prices is implemented by a reduction to the cost uplift factor. This reflects the reduced costs for providers in relation to the purchase of SCCL products. For nationally determined prices, the adjustment is 0.36%.

229. It is likely that opportunities to use SCCL services will differ between acute, mental health, community and ambulance services – for example, it is likely that acute providers have higher non-pay costs than mental health providers.

230. We used the following method for calculating adjustments to the cost uplift factor for different services:

- We estimated the amount of the total tariff adjustment.
- We then allocated this amount to the different service types (ie acute, ambulance, mental health and community), using trust definitions.
- The resulting amounts were divided by the respective trust income from patient care activities.

231. Table 7 shows both the reduction in the cost uplift for national prices (the acute figure) and the suggested reductions in the cost uplift factor to be used for local pricing (pursuant to rule 2 of the local pricing rules – see Section 6.4), based on different services’ share of SCCL overheads.

Table 7: Suggested reductions in cost uplift factor for local pricing

<table>
<thead>
<tr>
<th>Adjustment to the cost uplift factor</th>
<th>Acute</th>
<th>Mental health</th>
<th>Ambulance</th>
<th>Community</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0.36%</td>
<td>0.10%</td>
<td>0.08%</td>
<td>0.05%</td>
</tr>
</tbody>
</table>
4.8. Efficiency

232. The efficiency factor for 2019/20 is 1.1%.

233. We use evidence-based data to inform the decision on the efficiency factor. An econometric model, first developed by Deloitte to inform the decision on the efficiency factor for the 2015/16 NTPS, analyses cost variations between providers over time explained by i) the outputs they produce and ii) factors outside their control. The remaining trend over time is interpreted as trend efficiency and residual differences between trusts are used to estimate the distribution of efficiency across the sector.

234. The model now includes data from 168 acute trusts for the period between 2008/09 and 2016/17. We have also refined the measurement of disease prevalence in the model and conducted a range of additional sensitivity checks.55

235. Our modelling suggests that trusts become 0.9% more efficient each year on average. Around this trend, we estimate that there is substantial variation in efficiency that justifies an efficiency factor greater than 0.9%, ie on the assumption that poorer performers can improve their efficiency at a greater rate. If average performance catches up to the 60th centile, we estimate that this would release 1.1% efficiency in addition to trend efficiency.

236. However, adjusting the time period of the model highlighted that the delivery of efficiencies has slowed in recent years.

237. We have set an efficiency factor of 1.1% for 2019/20. We regard this as challenging but achievable given the evidence around catch-up potential and trends in efficiency and financial pressure.

4.9. Summary of cost adjustments

238. Table 8 summarises the cost uplift and efficiency adjustments (both for national prices and local prices).

55 Judgements are generally made on disease prevalence data due to breaks in the data. We apply the following principles when making these judgements: 1) interpolation and extrapolation are used to include as much information on disease as possible; 2) diseases with data gaps of more than three years are excluded and 3) changes in data definitions are managed by applying growth rates of the new series to the old series.
239. We have provided the changes by different service types to support local pricing in these areas. The adjustments to national prices use the factors for acute services. For local prices, the figures reflect the adjustments to which commissioners and providers should have regard pursuant to rule 2 of the local pricing rules (see Section 6.4). The only difference between different services is for the adjustment relating to changes to product procurement arrangements.

**Table 8: Summary of cost adjustments**

<table>
<thead>
<tr>
<th></th>
<th>Acute/ nationally priced services</th>
<th>Mental health</th>
<th>Ambulance</th>
<th>Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost uplift factor (before CQUIN and procurement adjustments)</td>
<td>3.8%</td>
<td>3.8%</td>
<td>3.8%</td>
<td>3.8%</td>
</tr>
<tr>
<td>CQUIN</td>
<td>1.25%</td>
<td>1.25%</td>
<td>1.25%</td>
<td>1.25%</td>
</tr>
<tr>
<td>Procurement changes</td>
<td>-0.36%</td>
<td>-0.10%</td>
<td>-0.08%</td>
<td>-0.05%</td>
</tr>
<tr>
<td>Efficiency factor</td>
<td>-1.1%</td>
<td>-1.1%</td>
<td>-1.1%</td>
<td>-1.1%</td>
</tr>
<tr>
<td>Total proposed adjustments</td>
<td>3.6%</td>
<td>3.9%</td>
<td>3.9%</td>
<td>3.9%</td>
</tr>
</tbody>
</table>

**Please note:** The pay element of the cost uplift factor includes the AfC pressure funded centrally in 2018/19 (2.1%), estimated 2019/20 AfC costs (3.4%), estimated medical pay award costs, including the full year effect of the 2018/19 pay award (3.1%) and incremental drift (0.1%). These figures are not cost-weighted and AfC is estimated at 75.20% of total pay costs. Excluding the 2018/19 AfC pay deal, the 3.8% cost uplift factor would be 2.8%.
5. National variations to national prices

240. In some circumstances, it is appropriate to make national adjustments to national prices. For example, adjustments may reflect local differences in costs that the formulation of national prices has not taken account of, or they may share risk more appropriately among parties.

241. We refer to these nationally determined adjustments as ‘national variations’ to national prices. We refer to the price, after application of national variations, as the ‘nationally determined price’.

242. Specifically, each national variation aims to achieve one of the following:

- improve the extent to which the actual prices paid reflect location-specific costs
- improve the extent to which the actual prices paid reflect the complexity of patient need
- share the financial risk appropriately following (or during) a move to other payment approaches.

243. This section sets out the national variations specified in the 2019/20 NTPS.

244. The national variations have changed from those in the 2017/19 NTPS in these areas:

- We have revised the calculation method and data used for the market forces factor (MFF). Providers will transition to their new MFF values over a five-year period in equal steps.
- We have removed the marginal rate emergency tariff (MRET) and 30-day readmission rules, given the blended payment approach for emergency care (see Section 7).
- We have updated the specialist top-ups payable.
- We have removed the reference to ‘transition’ from the variation supporting the best practice tariff for primary hip and knee replacements. This variation will be reviewed as part of the standard tariff development cycle.
- We have added a new national variation for evidence-based interventions.
245. National variations are an important part of the payment system framework. They sit alongside local variations and local modifications. Providers and commissioners should note:

- national variations only apply to services with a national price
- if a commissioner and a provider choose to bundle services that have a mix of national prices and locally determined prices, national variations can in effect be disapplied or modified by local variations agreed in accordance with the applicable rules (see Section 6.2)
- in the case of an application or agreement for a local modification (see Section 6.3), the analysis must reflect all national variations that could alter the price payable for a service (ie it is the price after any national variations have been applied that should be compared with a provider’s costs)
- where a new service is commissioned that does not have a national price, rules for local price setting apply (see Section 6.4).

246. The rest of this section covers three types of national variation to national prices:

- variations to reflect regional cost differences
- variations to reflect patient complexity
- variations to support different payment approaches.

5.1. Variations to reflect regional cost differences: the market forces factor

247. The purpose of the MFF is to compensate providers for unavoidable cost differences in providing healthcare services. Unavoidable costs include variations in capital, building, business rates and labour costs.

248. The MFF takes the form of an index. This allows a provider’s location-specific costs to be compared with every other organisation. The index is constructed so that it always has a minimum value of 1.00. The MFF payment index operates as a multiplier to each unit of activity. The example below explains how this works in practice.
A patient attends an NHS trust for a first outpatient attendance, which has a national price of £168.

The NHS trust has an MFF payment index value of 1.0461.

The income that the trust receives from the commissioner for this outpatient attendance is £176 (£168 x 1.0461).

249. Further information on the calculation and application of the MFF is provided in the supporting document, *A guide to the market forces factor*. This guide has been revised for 2019/20.

250. For 2019/20 we have revised the calculation method and data used for the MFF. This means that all organisations have been assigned new MFF values. The new values will be phased in over a five-year period in equal steps.

251. The MFF payment index values for 2019/20 (after application of the five-year transition) for each NHS provider are in Annex DtA.

252. The MFF value for independent sector providers should be the MFF value of the NHS trust or foundation trust nearest to the location where the services are being provided.

253. Where NHS providers outsource the delivery of entire services to other providers, consideration needs to be given to the MFF that is applied. For example, if provider A seeks to outsource the delivery of a service to provider B in such a way that the patient is recorded as provider B’s activity (ie provider B will bill the commissioner for the activity) but the activity is still delivered at the provider A site, then the relative MFFs of the two providers must be considered:

- If provider B has a higher MFF, discussion with the commissioner is needed to agree an appropriate price in the light of the lower unavoidable costs they will incur.
- Conversely, if provider B has a lower MFF, then discussion with the commissioner is needed to ensure the provider is adequately compensated for the delivery of the service.

254. Organisations merging or undergoing other organisational restructuring after 1 April 2019 will not have a new MFF set during the period covered by the tariff.
For further guidance in these circumstances see the supporting document, *A guide to the market forces factor*.

255. Where there is a relevant acquisition or merger on or prior to 1 April 2019, a new MFF will be calculated and will apply from 1 April 2019. Providers should notify NHS Improvement by email (pricing@improvement.nhs.uk) of any planned changes that might affect the MFF index.

5.2. **Variations to reflect patient complexity**

5.2.1. **Top-up payments**

256. National prices in this national tariff are calculated on the basis of average costs. This means they do not take account of cost differences between providers because some providers serve patients with more complex needs. The purpose of top-up payments for some specialised services is to recognise these cost differences and to improve the extent to which prices paid reflect the actual costs of providing healthcare when this is not sufficiently differentiated in the HRG design. Only a few providers are commissioned to deliver such care.

257. To set payments, we make an adjustment (a top-slice) to the total amount of money allocated to national prices and reallocate this money to providers of specialised services.

258. Specialised service top-ups have been part of the payment system since 2005/06. The current list of qualifying specialised services, and the design and calculation of specialised top-ups for these services, are informed by research undertaken in 2011 by the Centre for Health Economics at the University of York.56

259. The amounts paid and the providers that are eligible are based on the prescribed specialised services (PSS) definitions provided by the NHS England specialised commissioning team. The list of eligible providers is contained within the PSS operational tool.57

260. Top-up payments are only made for inpatient care. Table 9 shows the breakdown of the amount received by various areas as a result of the top-ups.

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This includes the second step in the transition of the difference in income for some services as a result of the move to PSS and HRG4+.

**Table 9: Top-up impact by specialist area 2019/20**

<table>
<thead>
<tr>
<th>Top-up area</th>
<th>Top-up amounts</th>
</tr>
</thead>
<tbody>
<tr>
<td>All top-up areas</td>
<td>£485.9m</td>
</tr>
<tr>
<td>Spinal</td>
<td>£10.3m</td>
</tr>
<tr>
<td>Neurosciences</td>
<td>£117.1m</td>
</tr>
<tr>
<td>Orthopaedics</td>
<td>£3.1m</td>
</tr>
<tr>
<td>Children</td>
<td>£171.9m</td>
</tr>
<tr>
<td>Cancer</td>
<td>£19.7m</td>
</tr>
<tr>
<td>Respiratory</td>
<td>£72.2m</td>
</tr>
<tr>
<td>Cardiac</td>
<td>£74.5m</td>
</tr>
<tr>
<td>Other</td>
<td>£17.1m</td>
</tr>
</tbody>
</table>

261. We have changed the top-ups payable for 2019/20 based on the most up-to-date PSS identification rules, hierarchy and provider eligibility lists.

262. A list of the services eligible for top-ups, the adjustments and their flags can be found in Annex DtA.

5.3. **Variations to support new payment approaches**

263. New or changing payment approaches can alter provider income or commissioner expenditure. For some organisations, the financial impact can be significant and could be difficult to manage in one step.

5.3.1. **Best practice tariff for primary hip and knee replacements**

264. For 2019/20 onwards, the primary hip and knee replacement BPT introduced in 2014/15 to promote improved outcomes for patients is no longer being treated as transitional. It will be reviewed as part of the standard tariff development cycle.
265. We are retaining the approach adopted in 2014/15, which recognised that there are circumstances in which some providers will be unable to demonstrate that they meet all the best practice criteria, but where it would be inappropriate not to pay the full BPT price. These circumstances are:

• when recent improvements in patient outcomes are not yet reflected in the nationally available data
• when providers have identified why they are an outlier on patient-reported outcome measures (PROMs) scores and have a credible improvement plan in place, the impact of which is not yet known
• when a provider has a particularly complex casemix that is not yet appropriately taken into account in the casemix adjustment in PROMs.

266. Under this national variation, commissioners must pay the full BPT if the provider can show that any of the above circumstances apply. The rationale for using a variation in these three circumstances is explained below.

Recent improvements

267. Because of the lag between collecting and publishing data, recent improvements in patient outcomes may not show in the latest available data. In these circumstances, providers will need to provide other types of evidence to support a claim that their outcomes have improved since the published data was collected.

Planned improvements

268. Where providers have identified shortcomings with their service and can show evidence of a credible improvement plan, commissioners must continue to pay the full BPT. This is necessary to mitigate the risk of deteriorating outcomes among providers not meeting the payment criteria.

269. In this situation, the variation would be a time-limited agreement. Published data would need to show improvements for payment at the BPT level to continue.

270. There are many factors that may affect patient outcomes, and it is for local providers and commissioners to decide how to achieve improvements, but these suggestions may be useful:
• Headline PROMs scores can be broken down into individual domain scores. If required, providers can also request access to individual patient scores through NHS Digital. Providers might look at the questions on which they score badly to see why they are an outlier: for example, those relating to pain management.

• Individual patient outcomes might also be compared with patient records to check for complications in surgery or comorbidities that may not be accounted for in the formal casemix adjustment. It would also be sensible to check whether patients attended rehabilitation sessions after being discharged from hospital.

• Reviewing the surgical techniques and prostheses used against clinical guidelines and National Joint Registry recommendations is another way providers might try to address poor outcomes. As well as improving the surgical procedure itself, providers could scrutinise the whole care pathway to improve patient outcomes by ensuring that weakness in another area is not affecting patient outcomes after surgery.

• Providers may also choose to collaborate with others that have outcomes significantly above average to learn from their service design. Alternatively, they might do a clinical audit. This is a quality improvement process that seeks to improve patient care and outcomes through a systemic review of care against expected criteria.

Casemix

271. Providers that have a particularly complex casemix and cannot show they meet the best practice criteria may request that the commissioner continues to pay the full BPT. Although the PROMs results are adjusted for casemix, a small number of providers may face an exceptionally complex casemix that is not fully or appropriately accounted for. These providers will therefore be identified as outliers in the PROMs publications. Commissioners are likely to be aware of such cases already and must agree to pay the full BPT. We anticipate that any such agreement will only be valid until the casemix adjustment in PROMs better reflects the complexity of the provider’s casemix.

5.3.2. Evidence-based interventions

272. Research evidence shows that some interventions are not clinically effective or only effective when they are performed in specific circumstances. As medical
science advances, some interventions are superseded by those that are less invasive or more effective.

273. Following a 2018 consultation on evidence-based interventions, this national variation means that if the following procedures are undertaken, they will not attract reimbursement unless a successful individual funding request (IFR) is made:

• snoring surgery (in the absence of obstructive sleep apnoea (OSA))
• dilatation and curettage (D&C) for heavy menstrual bleeding (HMB) in women
• knee arthroscopy for patients with osteoarthritis
• injections for non-specific low back pain.
6. **Locally determined prices**

274. National prices can sometimes be adjusted through local variations or, where they do not adequately reimburse efficient costs because of certain issues, through local modifications. Where there are no national prices, commissioners and providers must determine local prices in accordance with any rules specified in the national tariff.

275. This section sets out the principles that apply to all locally determined prices (Section 6.1). It contains the rules for local variations (Section 6.2) and the method used by NHS Improvement to assess local modifications (Sections 6.3) and rules on local prices (Section 6.4). Annex DtG sets out guidance on the application of the principles, rules and method.\(^{58}\)

276. Emergency care services are no longer subject to national prices. The local prices for those services are, however, to be determined in accordance with the detailed rules in Section 7 rather than agreed in accordance with the local pricing rules in Section 6.4.

277. This section is supported by the following annexes and supporting documents:\(^ {59}\)

- Annex DtG: Guidance on locally determined prices
- Annex DtC: Currencies with no national price
- Annex DtA: National tariff workbook, which lists high cost drugs, devices and procedures
- Annex DtE: Mental health clustering tool
- Guidance on blended payment for mental health services.

278. It is also supported by the following documents available here:\(^ {60}\)

- local variations template (relevant to Section 6.2)
- local modifications template (relevant to Section 6.3)
- local prices template (relevant to Section 6.4).

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\(^{58}\) Commissioners have a duty to have regard to such guidance under the 2012 Act, Section 116(7).

\(^{59}\) All available to download from: [https://improvement.nhs.uk/resources/national-tariff-1920-consultation/](https://improvement.nhs.uk/resources/national-tariff-1920-consultation/)

6.1. **Principles applying to all local variations, local modifications and local prices**

279. Commissioners and providers must apply the following three principles when agreeing a local payment approach:

- The approach must be in the **best interests of patients**.
- The approach must **promote transparency** to improve accountability and encourage the sharing of best practice.
- The provider and commissioner(s) must **engage constructively** with each other when trying to agree local payment approaches.

280. These principles are explained in more detail in sections 6.1.1 to 6.1.3 and are additional to other legal obligations on commissioners and providers. These obligations include other rules set out in the national tariff, and the requirements of competition law, procurement law, regulations under Section 75 of the 2012 Act,\(^{61}\) and NHS Improvement’s provider licence.

281. The pricing of emergency care is subject to the detailed rules in Section 7 and the local pricing principles do not apply.

6.1.1. **Best interest of patients**

282. Local variations, modifications and prices must be in the best interests of patients today and in the future. In agreeing a locally determined price, commissioners and providers must therefore consider the following factors:

- **Quality**: how will the agreement maintain or improve the clinical effectiveness, patient experience and safety of healthcare today and in the future?
- **Cost-effectiveness**: how will the agreement make healthcare more cost effective, without reducing quality, to enable more effective use of resources for patients today and in the future?
- **Innovation**: how will the agreement support, where appropriate, the development of new and improved service delivery models which are in the best interests of patients today and in the future?

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\(^{61}\) See the National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2013 (SI 2013/500).
• Allocation of risk: how will the agreement allocate the risks associated with unit costs, patient volumes and quality in a way that protects the best interests of patients today and in the future?

6.1.2. Transparency

283. Local variations, modifications and prices must be transparent. Increased transparency will make commissioners and providers more accountable to each other, patients, the general public and other interested stakeholders. Transparent agreements also mean that best practice examples and innovation in service delivery models or payment approaches can be shared more widely. In agreeing a locally determined price, commissioners and providers must therefore consider the following factors:

• Accountability: how will relevant information be shared in a way that allows commissioners and providers to be held to account by one another, patients, the public and other stakeholders?
• Sharing best practice: how will innovations in service delivery or payment approaches be shared in a way that spreads best practice?

6.1.3. Constructive engagement

284. Providers and commissioners must engage constructively with each other to decide on the mix of services, delivery model and payment approach that deliver the best value for patients in their local area. This process should involve clinicians, patient groups and other relevant stakeholders where possible. It should also facilitate the development of positive working relationships between commissioners and new or existing providers over time, as constructive engagement is intended to support better and more informed decision making in both the short and long term.

285. In agreeing a locally determined price, commissioners and providers must therefore consider the following factors:

• Framework for negotiations: Have the parties agreed a framework for negotiating local variations, modifications and prices that is consistent with
the existing guidelines in the NHS Standard Contract and procurement law (if applicable)?

- **Information sharing:** Are there agreed policies for sharing relevant and accurate information in a timely and transparent way to facilitate effective and efficient decision-making?

- **Involvement of relevant clinicians and other stakeholders:** Are relevant clinicians and other stakeholders, such as patients or service users, involved in the decision-making process?

- **Short- and long-term objectives:** Are clearly defined short- and long-term strategic objectives for service improvement and development agreed before starting price negotiations?

### 6.2. Local variations

286. Local variations are adjustments to a national price or a currency for a nationally priced service (or both), agreed by one or more commissioners and one or more providers. They only affect services specified in the agreement and the parties to that agreement. A local variation can be agreed for more than one year, although it must not last longer than the relevant contract. Each variation applies to an individual service with a national price. However, commissioners and providers can enter into agreements that cover multiple variations to several related services.

287. Local variations allow a flexible approach and can be considered in many different situations, where providers and commissioners feel that it would be appropriate to adopt a local pricing arrangements. Local variations can be used to adopt a wide variety of payment approaches. Examples could include the following:

- payment based on an agreed level of activity and associated spend, overlaid with a gain and loss share
- whole population budget (WPB), overlaid with a gain and loss share.

288. However, this is not an exhaustive list and it is for commissioners and providers to determine the approaches that would be most appropriate locally.

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62 The NHS Standard Contract is used by commissioners of healthcare services (other than those commissioned under primary care contracts) and is adaptable for use for a broad range of services and delivery models.

63 Local variations are covered by Sections 116(2), 116(3) and 118(4) of the 2012 Act.
289. When agreeing local variations, providers and commissioners would need to have regard to the locally-determined pricing principles (see Section 6.1) and the rules set out below.

6.2.1. Rules for local variations

290. For a local variation to be compliant with the national tariff, commissioners and providers must comply with the following rules.64

Rules for local variations

1. The commissioner and provider must apply the principles set out in Section 6.1 when agreeing a local variation.

2. The local variation must be documented in the commissioning contract between the commissioner and provider for the service to which the variation relates.

3. The commissioner must submit a written statement of the local variation to NHS Improvement using the local variation template. NHS Improvement will publish the templates it receives on behalf of the commissioner.

4. The deadline for submitting the statement is 30 June 2019. For local variations agreed after this date, the deadline is 30 days after the agreement.

291. Under the 2012 Act, commissioners must maintain and publish a written statement of any local variation.65 They should publish each statement by 30 June 2019, or within 30 days of the variation agreement if the variation is agreed after this date. These statements (which can be combined for multiple services) must include details of previously agreed variations for the same services.66 Commissioners must therefore update the statement if they agree changes to the variations covered by the statement.

292. Commissioners are required to make a written statement of each local variation and submit these to NHS Improvement. Commissioners should use the template provided by NHS Improvement to prepare the written statement. (The template can be downloaded from NHS Improvement’s Pricing Portal.)67 The

64 The rules in this section are made under the 2012 Act, Section 116(2).
65 2012 Act, Section 116(3).
66 2012 Act, Section 116(3)(b).
67 https://ldp.monitor-nhsft.gov.uk/
completed template should be included in the commissioning contract (Schedule 3 of the NHS Standard Contract).

293. NHS Improvement will publish these templates on its Pricing Portal so that all agreed local variations are accessible to the public from a single location. Where NHS Improvement publishes the template, it will do so on behalf of the commissioner for the purposes of Section 116(3) of the 2012 Act (the commissioner’s duty to publish a written statement). Commissioners may take other additional steps to publish the details of the local variations (eg making the written statement available on their own website).

6.3. Local modifications

6.3.1. What are local modifications?

294. Local modifications are intended to ensure that healthcare services can be delivered where they are required by commissioners for patients, even if the nationally determined price for the services would otherwise be uneconomic.

295. Local modifications can only be used to increase the price for an existing currency or set of currencies. Each local modification applies to a single service with a national price (eg an HRG). In practice several services could be uneconomic as a result of similar cost issues.

296. There are two types of local modification:

- Agreements: where a provider and one or more commissioners agree a proposed increase to a nationally determined price for a specific service. For local modification agreements, NHS Improvement requires commissioners and providers to prepare joint submissions.68
- Applications: where a provider is unable to agree an increase to a nationally determined price with one or more commissioners and instead applies to NHS Improvement to increase that price.

297. Local modifications are subject to approval (in the case of local modification agreements) or grant (in the case of local modification applications) by NHS Improvement.69 To be approved or granted, NHS Improvement must be

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68 Submission templates can be found at: www.gov.uk/guidance/nhs-providers-and-commissioners-submit-locally-determined-prices-to-monitor#local-modifications

69 The legislation governing local modifications is set out in the 2012 Act, Part 3, Chapter 4. The legal framework for local modifications is principally described in Sections 116, 124, 125 and 126.
satisfied that providing a service at the nationally determined price would be uneconomic without the local modification.

6.3.2. Overview of our method for determining local modifications

298. NHS Improvement’s method\textsuperscript{70} is intended to identify cases where a local modification is appropriate for a provider with costs of providing a service (or services) that are higher than the nationally determined price(s) for that service (or services). Applications and agreements\textsuperscript{71} must be supported by sufficient evidence to enable NHS Improvement to determine whether a local modification is appropriate, based on our method.

299. NHS Improvement’s method requires that commissioners and providers:

\begin{itemize}
  \item apply the principles outlined in Section 6.1
  \item demonstrate that services are uneconomic in accordance with Section 6.3.3
  \item comply with our conditions for local modification agreements and applications set out in Sections 6.3.4 to 6.3.6.
\end{itemize}

300. NHS Improvement will determine the circumstances or areas in which the modified price is to be payable (subject to any restrictions on the circumstances or areas in which the modification applies).

301. NHS Improvement may take into account previously agreed local modifications when considering an agreement to extend a local modification, in cases where it can be demonstrated that the underlying issues have not changed.

6.3.3. Determining whether services are uneconomic

302. NHS Improvement’s method involves determining whether the provision of the service at the nationally determined price would be uneconomic and applying additional conditions. In relation to determining whether the provision of the service is uneconomic, local modification agreements and applications must demonstrate the following:

\begin{itemize}
  \item The provider’s average cost of providing each service is higher than the nationally determined price.
\end{itemize}

\textsuperscript{70} Under the 2012 Act, Monitor is required to publish in the national tariff its methods for deciding whether to approve local modification agreements or grant local modification applications.

\textsuperscript{71} The 2012 Act, Section 124(4), requires that an agreement submitted to Monitor must be supported by such evidence as Monitor may require.
• The provider’s average costs are higher than the nationally determined prices as a result of issue(s) that are:
  – **specific**: the higher costs should only apply to a particular provider or subset of providers and should not be nationally applicable; for example, we would not normally consider an issue to be specific if a large number of providers have costs that are similarly higher than the national price
  – **identifiable**: the provider must be able to identify how the issue(s) it faces affect(s) the cost of the services
  – **non-controllable**: the higher costs should be beyond the direct control of the provider, either currently or in the past. Previous investment decisions that continue to contribute to high costs for particular services may reflect management choices that could have been avoided (for example private finance initiatives). Similarly, antiquated estate may reflect a lack of investment rather than an inherent feature of the local healthcare economy. In both such cases, we will not normally consider the additional costs to be non-controllable. This means that higher costs as a result of previous investment decisions or antiquated estate are unlikely to be grounds for a local modification. Any differences between a provider’s costs and those of a reasonably efficient provider when measured against an appropriately defined group of comparable providers would also be considered to be controllable. NHS Improvement also considers CNST costs to be controllable and therefore unlikely to be the grounds for a local modification
  – **not reasonably reflected elsewhere**: the costs should not be adjusted elsewhere in the calculation of national prices, rules or variations, or reflected in payments made under the Provider Sustainability Fund and/or Financial Recovery Fund.\(^\text{72}\)

303. Local modification agreements and applications must also propose a modification to the nationally determined prices of the relevant services that specifies the circumstances or areas in which the proposed modification is to apply, and the expected volume of activity for each relevant commissioner for the relevant period (which must not exceed the period covered by the national tariff).

\(^{72}\) NHS Improvement may take into account any payment received by a provider under the Provider Sustainability Fund and/or Financial Recovery Fund when determining the amount of the local modification to be approved.
6.3.4. Additional condition for local modification agreements

304. The agreement must specify the services that will be affected, the circumstances or areas in which the modification is to apply, the start date of the local modification and the expected volume of activity for the period of the proposed local modification (which must not exceed the period covered by the national tariff). 73

6.3.5. Additional conditions for local modification applications

305. For local modification applications, five additional conditions must also be satisfied. The applicant provider must:

• demonstrate it has a deficit equal to or greater than 4% of revenues at an organisational level in 2018/19; see Annex DtG (Section 4.6) for guidance on how providers should calculate deficits for the purpose of this condition
• demonstrate that the services are commissioner-requested services (CRS) 74 or, in the case of NHS trusts or other providers that are not licensed, that the provider cannot reasonably cease to provide the services
• demonstrate it has first engaged constructively with its commissioners 75 to try to agree alternative means of providing the services at the nationally determined price and, if unsuccessful, has engaged constructively to reach a local modification agreement before submitting an application 76 to NHS Improvement
• specify the services affected by the proposed local modification, the circumstances or locations in which the proposed modification is to apply, and the expected volume of activity for each relevant commissioner for the current financial year
• submit the application to NHS Improvement by 30 September 2019, unless there are exceptional circumstances (for example, where there is a clear and immediate risk to patients).

73 The start date for a local modification can be earlier than the date of the agreement, but no earlier than the date the national tariff takes effect (as required by the 2012 Act, Section 124(2)).
74 See: Guidance for commissioners on ensuring the continuity of health services; Designating commissioner requested services and location specific services, 28 March 2013.
75 Constructive engagement is also required by condition P5 of the provider licence, in cases where a provider believes that a local modification is required.
76 Submission templates can be found at: www.gov.uk/guidance/nhs-providers-and-commissioners-submit-locally-determined-prices-to-monitor#local-modifications
306. NHS Improvement reserves the right to grant an application, in exceptional circumstances, even if the conditions set out above have not been met.

6.3.6. Dates

Applications

307. If an application for a local modification is successful, NHS Improvement will determine the date from which the modification will take effect. In most cases, applications will be effective from the start of the following financial year, subject to any changes in national prices, to allow commissioning budget allocations to take account of decisions.

308. In exceptional cases (particularly where delay would cause unacceptable risk of harm to patients), NHS Improvement will consider making the modification effective from an earlier date.

Agreements

309. The terms of a local modification agreement should be included in the relevant commissioning contract (using the NHS Standard Contract where appropriate)\(^77\) once they are agreed between the provider and commissioner. If the terms of a local modification agreement are included in the commissioning contract before NHS Improvement approves the local modification, the contract may provide for payment of the modified price pending a decision by NHS Improvement. But if NHS Improvement subsequently decides not to approve the modification, the modification would not have effect and the national price would apply. The provider and commissioner must then agree a variation to the commissioning contract to stop the modification and they may agree a mechanism for adjustment and reconciliation in relation to the period before the refusal, or possibly a local variation to the national price.

310. The start date for a local modification can be earlier than the date of the agreement, but no earlier than the date the national tariff takes effect (as required by the 2012 Act, Section 124(2)).

\(^77\) Providers and commissioners should refer to the latest available guidance on the NHS Standard Contract: www.england.nhs.uk/nhs-standard-contract.
6.4. Local prices

311. For many NHS services there are no national prices. Some of these services have nationally specified currencies, but others do not. In both cases, commissioners and providers must work together to agree prices for these services. The 2012 Act confers on NHS Improvement the power to set rules for local price setting of such services, as agreed with NHS England, including rules specifying national currencies for such services. We have set both general rules and rules specific to particular services. For services other than emergency care, there are two types of general rule:

- Rules that apply in all cases when a local price is set for services without a national price (see Section 6.4.1).
- Rules that apply only to local price setting for services with a national currency but no national price (see Section 6.4.2).

312. As well as the general rules, there are rules specific to particular services (see Sections 6.4.3 to 6.4.7).

313. In addition, Section 7 sets out the separate rules for emergency care services. The rules in this Section do not apply to those services.

314. Annex DtG provides additional guidance on the application of the local pricing rules.

315. Table 14 shows which rules apply to which area of activity.

### Table 14: Application of pricing rules

<table>
<thead>
<tr>
<th>Rule</th>
<th>Acute</th>
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<th>Community</th>
<th>Ambulance</th>
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<td>✓</td>
<td>×</td>
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</tr>
</tbody>
</table>

78 2012 Act, Section 116(4)(b) and (12) and Section 118(5)(b).
6.4.1. General rules for all services without a national price

316. Rules 1 and 2 apply when providers and commissioners agree local prices for services without national prices (other than emergency care services). The rules apply irrespective of whether there is a national currency specified for the service.

**Local pricing rules: general rules for all services without a national price**

**Rule 1**
Providers and commissioners must apply the principles in Section 6.1 when agreeing prices for services without a national price.

**Rule 2**
Commissioners and providers should have regard to the efficiency and cost adjustments for 2019/20 (as set out in Sections 4.7 and 4.8 and summarised in Section 4.9) when setting local prices for services without a national price for 2019/20.

6.4.2. General rules for services with a national currency but no national price

317. Services that have national currencies but no national price are:

- working-age and older people **mental health services** and **IAPT**
- **ambulance services**
- the following **acute services**:  
  - specialist rehabilitation (25 currencies based on patient complexity and provider/service type)  
  - critical care – adult and neonatal (13 HRG-based currencies)  
  - HIV adult outpatient services (three currencies based on patient type)
– renal transplantation (nine HRG-based currencies)
– dialysis for acute kidney injury
– positron emission tomography and computed tomography (PET/CT)
– wheelchair services
– spinal cord injury services.

318. Details of these currencies are set out in Annex DtC, apart from PET/CT which has HRGs listed in Annex DtA.

319. The blended payment for emergency care in effect sets national currencies for emergency care (see Section 7). However, this is not covered by rules 3 and 4 and Annex DtC.

320. The following rules apply when providers and commissioners are setting local prices for the services specified in paragraph 317.

**Local pricing rules: general rules for services with a national currency but no national price**

**Rule 3**

**(a)** Where a national currency is specified for a service, it must be used as the basis for local price setting for the service covered by that national currency, unless an alternative payment approach is agreed in accordance with Rule 4 below.

**(b)** Where a national currency is used as the basis for local price setting, providers must submit details of the agreed unit prices for those services to NHS Improvement using the standard templates provided by NHS Improvement.

**(c)** The completed templates must be submitted to NHS Improvement by 30 June 2019. For local prices agreed after this date, the deadline is 30 days after the agreement.

**(d)** The national currencies specified for the purposes of this rule and Rule 4 are the currencies specified in Annex DtC.
Rule 4

(a) Where there is a national currency specified for a service, but the commissioner and provider of that service wish to move away from using it, the commissioner and provider may agree a price without using the national currency.

When doing so, providers and commissioners must adhere to the requirements (b), (c), (d) and (e) below, which are intended to mirror the requirements for agreeing a local variation for a service with a national price, set out in Section 6.2.

(b) The agreement must be documented in the NHS Standard Contract between the commissioner and provider which covers the service in question.

(c) The commissioner must maintain and publish a written statement of the agreement, using the template provided by NHS Improvement, within 30 days of the relevant contract being signed or, in the case of an agreement during the term of an existing contract, the date of the agreement.

(d) The commissioner must have regard to the guidance in Section 6.2 when preparing and updating the written statement.

(e) The commissioner must submit the written statement to NHS Improvement.

321. The templates referred to in Rule 3 can be found here.79

6.4.3. High cost drugs, devices and listed procedures

322. A number of high cost drugs, devices and listed procedures are not reimbursed through national prices. Instead, they are subject to local pricing in accordance with the rule below. Annex DtA sets out the updated list of excluded drugs, devices and procedures for the 2019/20 NTPS that are subject to local prices.

Local pricing rules: rules for high cost drugs, devices and listed procedures

Rule 5:

(a) As high cost drugs, devices and listed procedures are not national currencies, rules 3 and 4 in Section 6.4.2, including the requirement to disclose unit prices to NHS Improvement, do not apply.

(b) Local prices for high cost drugs, devices or listed procedures must be paid as well as the relevant national price for the currency covering the core activity.

However, the price for the drug, device or procedure must be adjusted to reflect any part of the cost already captured by the national price.

**c)** The price agreed should reflect:

i. if there is a reference price for a drug specified as having been set at a level to incentivise provider uptake of the drug, that reference price; or

ii. if no such price is specified, the actual cost to the provider, or the nominated supply cost, or any other applicable reference price, whichever is lowest.

**d)** As the price agreed should reflect either the actual cost, or the nominated supply cost, or a reference price, the requirement to have regard to efficiency and cost adjustments detailed in Rule 2 does not apply.

**e)** The ‘nominated supply cost’ is the cost which would be payable by the provider if the device or drug was supplied in accordance with a requirement to use a supplier or intermediary, or via a framework, specified by the commissioner, pursuant to a notice issued under SC 36.50 of the NHS Standard Contract (nominated supply arrangements). The reference prices are set by NHS England and are based on the current best procured price achieved for a product or group of products by the NHS, or set at a level to incentivise provider uptake of a particular drug.

### 6.4.4. Mental health services

323. This section sets out the local pricing rules for IAPT services and mental health services for working-age adults and older people. In addition to rules 1 to 4, providers and commissioners must adhere to the requirements of rules 6 to 9.

**Local pricing rules: rules for mental health services**

**Rule 6: Using the mental healthcare clusters**

All providers of services covered by the care cluster currencies (see Annex DtE) must record and submit the cluster data to NHS Digital as part of the Mental Health Services Dataset, whether or not they have used the care clusters as the basis of payment. This should be completed in line with the mental health clustering tool (Annex DtE) and mental health clustering booklet to assign a care cluster classification to patients.
Rule 7: Local prices for mental health services for working-age adults and older people

(a) Subject to rule 7(b), providers and commissioners must adopt a blended payment approach in relation to mental health services for working-age adults and older people. The blended payment approach should include:

i. a fixed element based on forecast activity
ii. a variable element
iii. an element linked to quality and outcome measures and the delivery of access and wait standards
iv. an optional risk share agreement, if providers and commissioners consider this appropriate locally.

(b) Providers and commissioners can agree an alternative payment approach, as long as they apply the local pricing principles in Section 6.1 and comply with the procedure for departing from a national currency specified in rule 4.

Rule 8: Local prices for Improving Access to Psychological Therapies (IAPT)

(a) Providers and commissioners must use an outcomes-based payment model for IAPT services. The model must reflect the 10 national outcome measures collected in the IAPT dataset.

(b) All providers of IAPT services are required to submit the IAPT dataset to NHS Digital, whether or not the person receiving services is covered by a care cluster.

Rule 9: Patient choice

Providers and commissioners must ensure that any agreed payment approach enables appropriate patient choice.

6.4.5. Ambulances services

324. This section sets out the rules for local price-setting for ambulance services with and without national currencies.

325. In addition to rules 1 to 4, providers and commissioners must adhere to the requirements of rule 10.

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80 Providers and commissioners can agree local variations from these rules if they meet the requirements of our rules on local variations.
Local pricing rules: rule for ambulance services

Rule 10

Quality and outcome indicators must be agreed locally and included in the commissioning contracts covering the services in question.

6.4.6. Primary care services

326. Primary care is a core component of NHS care provision. It enables local populations to access advice, diagnosis and treatment. Primary care services cover a range of activities, including:

- providing co-ordinated care and support for general health problems
- helping people maintain good health
- referring patients on to more specialist services where necessary.

327. Primary care is also a key part of the provision of community-based health services, interacting with a number of other community-based health teams, such as community nurses, community mental health teams and local authority services.

Primary care payments determined by, or in accordance with, the NHS Act 2006 framework

328. The rules on local price setting (as set out in Section 6.4) do not apply to the payments for primary care services which are determined by, or in accordance with, regulations or directions, and related instruments, made under the primary care provisions of the National Health Act 2006 (chapters 4 to 7). This includes, for example, core services provided by general practices under General Medical Services (GMS) contracts. For 2019/20, the national tariff will not apply to payments for these services.

Primary care payments that are not determined by, or in accordance with, the NHS Act 2006 framework

329. The national tariff covers all NHS services provided in a primary care setting where the price payable for those services is not determined by or in accordance with the regulations, directions and related instruments made under the NHS Act 2006. Therefore, where the price for services is determined by
agreement between NHS England, or a CCG, and the primary care provider, the rules for local payment must be applied. This includes:

- services previously known as ‘local enhanced services’ and now commissioned by CCGs through the NHS Standard Contract (eg where a GP practice is commissioned to look after patients living in a nursing or residential care home)
- other services commissioned by a CCG in a primary or community care setting using its power to commission services for its local population (eg walk-in or out-of-hours services for non-registered patients).\(^{81}\)

330. The price paid to providers of NHS services in a primary care setting in most of these instances will be locally agreed, and providers and commissioners of these services must therefore adhere to the general rules set out in Section 6.4.1.

6.4.7. Community services

331. Community health services cover a range of services that are provided at or close to a patient’s home. These include community nursing, physiotherapy, community dentistry, podiatry, children’s wheelchair services and primary care mental health services. The services provided by community providers are a vital component in the provision of care to older patients and those with long-term conditions.

332. Community providers often work closely with other NHS and social care providers, such as GPs and local authority services, and are a key contributor to developing more integrated health and social care and new care models.

333. Payment for community health services must adhere to the general rules set out in Section 6.4.1. This allows continued discretion at a local level to determine payment approaches that support high quality care for patients on a sustainable basis.

334. Where providers and commissioners adopt alternative care pathway payment approaches that result in the bundling of services covered, at least in part, by national prices, the rules for local variations must be followed (see Section 6.2).

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\(^{81}\) These are arrangements made under the NHS Act 2006, Section 3 or 3A.
335. NHS England, NHS Improvement and NHS Digital will be testing a new approach to the future funding of community healthcare. This will focus on five new currency areas: children and young people with disabilities; single episodes of care; long-term conditions; frailty; last year of life. The pilot will run through to March 2020 and work has already begun on recruiting pilot partners.
7. **Rules for emergency care services**

337. For the 2019/20 NTPS we are introducing a blended payment for emergency care services to support a more effective approach to resource and capacity planning for these services. The blended payment includes both a fixed and a variable element which are determined in accordance with the pricing rules set out below.

338. Further detailed guidance is available in the supporting document *Guidance on blended payment for emergency care*.

339. The introduction of blended payment removes emergency care services from the scope of national prices. Providers and commissioners must, however, apply the rules set out here to agree the amounts payable for emergency services.

340. Where local health systems have already moved – or in future agree to move – to a different payment system, they can maintain or adopt this, using the provision in the rules for local departure from the default approach (see rule 6).

**Rule 1 (general rule)**

a) Commissioners and providers must determine the prices payable for the provision of emergency care services in accordance with rules 2 to 6 below and having regard to guidance published by NHS Improvement and NHS England in relation to the pricing of those services.

b) Subject to rule 4(d), the local pricing rules specified in Section 6.4 do not apply to emergency care services.

c) ‘Emergency care services’ means:

i) all emergency admission spells (admission method code 21-25, 28, 2A-2D[^82]);

ii) emergency admission excess bed days;

iii) 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;

[^82]: Please see the NHS Data Dictionary for more details  
iv) all ambulatory/same day emergency care activity, even if in the financial year 2018/19 this was being coded as something other than an emergency admission or A&E attendance\textsuperscript{83};

v) activity that was outside the scope of national prices in 2018/19, but which falls within the descriptions (i) to (iv) above.

d) Emergency care services do not include, in particular:

i) all other admission method codes;

ii) specialised services commissioned by NHS England, both elective and non-elective;

iii) all unbundled elements, such as critical care spells associated with emergency admissions and high cost drugs and devices.

Rule 2 (agreeing activity levels)

a) Where:

i) a commissioner contracts with a provider for the provision of emergency care services for the financial year 2019/20, or

ii) a commissioner and provider accept that such services are to be provided by the provider (for the benefit of persons for which the commissioner is responsible) during some or all of that year without such a contract being in place,

the price payable for those services must be determined by reference to the value of planned activity.

b) The ‘value of planned activity’ is the value agreed by the commissioner and provider.

c) The commissioner and provider must agree the value on the following basis:

i) determine the planned level of activity to be provided by the provider for the commissioner; and

ii) calculate the value of that planned activity using the unit prices and expected casemix.

d) The ‘unit price’ for each individual service is:

\textsuperscript{83} The Ambulatory Emergency Care Network defines ambulatory care as ‘the provision of same day emergency care for patients being considered for emergency admission’.
i) the unit price (or, for activity which is eligible for a best practice tariff, the base or non-best practice price) specified in Annex DtA in relation to that service, as varied in accordance with:

(a) the national variations specified in Section 5, as if that unit price were a national price for that service, and

(b) the short-stay emergency adjustment, as specified in Annex DtA; or

ii) if there is no such unit price, the amount agreed between the commissioner and provider.

Rule 3 (the blended payment)

a) Subject to paragraph (f), if the value of planned activity for the financial year 2019/20 is £10 million or more, the price payable to the provider shall be a price for all the emergency care services provided during that year, calculated in accordance with paragraphs (b) to (e).

b) If the value of actual activity for the year equals the value of planned activity, the price payable will be value of planned activity subject to a deduction for the agreed 2017/18 value of both the MRET and 30-day readmission rules as confirmed by providers and commissioners as part of the Autumn 2018 data collection exercise (‘the fixed price’).

c) If the value of actual activity is more than the value of planned activity, the price payable will be the fixed price plus 20% of the difference between those values.

d) If the value of actual activity is less than the value of planned activity, the price payable will be the fixed price minus 20% of the difference between those values.

e) The value of actual activity must be calculated on the same basis as the value of planned activity (ie. using unit prices and casemix).

f) If activity within the scope of a best practice tariff (‘BPT activity’) meets the requirements for the payment of the BPT, as set out in Annex DtD, then the price payable in accordance with the paragraphs above is increased by the difference between the value of BPT the activity if paid at base (or non-best practice) price and the value of the BPT activity if paid at BPT price.
Rule 4 (locally agreed adjustments to the blended payment)

a) Where rule 2 applies, the price payable may be adjusted as agreed locally in accordance with paragraphs (a) and (b).

b) The commissioner and provider may agree amounts by which the actual activity may exceed or be less than planned activity, but where the price payable continues to be the fixed price.

c) Unless the commissioner and provider agree that it is not required, they must agree a ‘break glass’ provision to the effect that if the value of actual activity is above or below the value of planned activity by an agreed percentage:

i) the percentage rate or rates applicable in respect of the value of activity above or below this threshold is or will be those specified in the provision, instead of the 20% rate specified in rule 3(c) and (d), or

ii) such other pricing arrangements as are agreed by the commissioner and provider and specified in the provision shall have effect.

Rule 5 (services outside the blended payment)

b) This rule applies if a commissioner and provider agree or accept as referred to in rule 2(a), but the value of planned activity for the financial year 2019/20 is less than £10 million.

c) Where this rule applies, the commissioner and the provider must determine the price for the provision of the emergency care service in accordance with the following paragraphs.

d) If the service is specified in Annex DtA, the price payable shall be:

i) the unit price for that service as defined in rule 2(d) above or,

ii) if the relevant conditions are satisfied, the BPT price for that service.

e) If the service is not specified in Annex DtA, the price shall be agreed by the commissioner and provider in accordance with the local pricing rules in Section 6.4.

Rule 6 (local departures)

a) A commissioner and provider may agree to depart from the pricing arrangements for emergency services specified in rules 2 to 4, if they comply with the requirements in paragraphs (b) to (f), which are intended to mirror the
requirements for agreeing a local variation for a service with a national price, set out in Section 6.2.

b) The commissioner and provider must apply the local pricing principles in Section 6.1.

c) The agreement must be documented in the NHS Standard Contract between the commissioner and provider that covers emergency care services in question.

d) The commissioner must maintain and publish a written statement of the agreement, using the template provided by NHS Improvement, within 30 days of the relevant contract being signed, or in the case of an agreement during the term of an existing contract, the date of the agreement.

e) The commissioner must have regard to the guidance in Section 6.2 when preparing and updating the written statement.

f) The commissioner must submit the written statement to NHS Improvement.
8. Payment rules

341. The 2012 Act allows for the setting of rules relating to payments to providers where health services have been provided for the purposes of the NHS (in England).\(^8^4\)

8.1. Billing and payment

342. Billing and payment must be accurate and prompt, in line with the terms and conditions set out in the NHS Standard Contract. Payments to providers may be reduced or withheld in accordance with provisions for contractual sanctions set out in the NHS Standard Contract.

8.2. Activity reporting

343. For NHS activity where there is no national price, providers must adhere to any reporting requirements set out in the NHS Standard Contract.

344. For services with national prices, providers must submit data as required under SUS guidance.\(^8^5\)

345. The dates for reporting activity and making the reports available will be published on the NHS Digital website.\(^8^6\) NHS Digital will automatically notify subscribers to its e-bulletin when these dates are announced.

346. NHS England has approval from the Secretary of State to allow CCGs and commissioning support units (CSUs) to process a limited set of personal confidential data when it is absolutely necessary to do so, for invoice validation purposes. This approval is subject to a set of conditions. NHS England has published advice online\(^8^7\) about these conditions and sets the actions that CCGs, CSUs and providers must take to ensure they act lawfully.

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\(^8^4\) 2012 Act, Section 116(4)(c).
\(^8^5\) http://content.digital.nhs.uk/susguidance
\(^8^6\) https://digital.nhs.uk/services/secondary-uses-service-sus/payment-by-results-guidance