Key areas of work for the 2020 national tariff

Tariff engagement document
Key areas of work for the 2020 national tariff

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1. Introduction

1. The NHS Long Term Plan sets out the direction for the health system in England. The plan commits to reforming the payment system and moving away from activity-based payments to ensure a majority of funding is population-based. This will support the development of integrated care systems (ICSs) and, by moving payment away from activity- and setting-specific payments, it will allow local areas to develop new models of care around the needs of patients. The plan also sets out the goal of moving to a blended payment model for all services.

2. NHS England and NHS Improvement want to ensure that any changes to the payment system will:
   - 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 deliver the optimal level of care in the right place at the right time – and shared financial responsibility for levels of hospital activity
   - fairly reflect the costs incurred by efficient providers in delivering care and generate incentives for continuous improvements in efficiency
   - minimise transactional burdens, provide financial stability and reduce barriers to support service transformation.

3. It is in this context that we have been working to develop proposals for the next national tariff, due to come into effect from 1 April 2020.

4. Given the limited time for policy development work since the publication of the 2019/20 National Tariff Payment System (NTPS), and the significant changes to the payment system anticipated for the years ahead, we expect to propose the next tariff to last for one year – the 2020/21 NTPS.

5. During September 2019, we ran a series of engagement workshops to discuss policies that we were considering for the 2020/21 NTPS, with a particular focus on blended payment. We also held a series of webinars in August 2019
to set out our initial thinking on the potential blended payment design. The feedback from these sessions has allowed us to further develop our blended payment design, and the specific approaches that we are considering proposing for 2020/21 NTPS.

6. This document gives a brief description of the blended payment model and its potential application for specific service areas in the 2020/21 NTPS. It also summarises some other key areas of work where we are consider making proposals for the statutory consultation on the 2020/21 NTPS. You can give feedback by responding to our online survey. The deadline for comments is the end of 18 November 2019.

7. We will continue to analyse the feedback we received from the workshops and webinars, as well as that received through the online survey, as we finalise the proposals that are included in the statutory consultation on the 2020/21 NTPS. We will launch the statutory consultation as soon as possible after the UK general election.

8. In addition to the development of blended payment and other reforms to the core national tariff, we will bring forward for engagement complementary proposals for reform of the NHS Standard Contract. These are likely to include a proposed requirement for all NHS providers and commissioners to have in place a meaningful system collaboration and financial management agreement in their local health economy.

9. For instance, we could develop a model agreement which would, at a minimum, require local health systems to:

• describe behaviours expected in a collaborative health system
• set principles around open book accounting and transparency between partners
• describe processes for resolving disputes and dealing with decisions about how best to use available financial and other resources
• set out a mechanism, locally agreed between providers and commissioners, for overall financial management and risk sharing to support delivery of the system control total.

https://engage.improvement.nhs.uk/pricing-and-costing/2020-tariff-engagement
10. Areas which have already adopted or would like to adopt a more developed approach – including those operating a whole population budget and making use of the Integrated Care Provider contract – would be able to continue to do so via a local variation.

11. Details of the proposed contractual reforms to support and enhance delivery of the Long Term Plan commitment to move away from activity-based payments will be included in the consultation on the NHS Standard Contract.
2. Blended payment

What is blended payment?

12. Blended payment aims to deliver the payment system goals described in paragraph 2 and ensure that patients receive the right care in the right place at the right time. It is not a single approach, but rather is a framework that can be adapted to reflect local requirements. There could be multiple blended payment approaches within one local health system/ICS, tailored to the needs of different patient groups or services.

13. As opposed to episodic (activity-based) or block payment approaches that are currently widely used, blended payment involves an ‘intelligent’ fixed element. This is intelligent as it is based on forward-looking forecasts of activity and best available cost data. The fixed element is then combined with one or more of variable, risk-sharing and outcomes-based elements.

Figure 1: The core elements of blended payment

Blended payment comprises….

1. An intelligent fixed payment, set based on forward-looking forecasts of demand and best available cost data

   At least one of the following…

   • The proportions of contract value assigned to each element are not pre-determined and in theory any proportions could be considered, depending on the objectives for the service.
   • Although the fixed payment is the core element of blended payment, it will not necessarily comprise the largest proportion by value.

2. A variable payment, setting a price for each unit of activity, either at full cost or an agreed marginal cost

   • Elements 2-4 can incentivise desired behavioural change, mitigate risks created by uncertainties in setting the fixed payment, facilitate patient choice, etc.
   • The choice of these elements will be based on the objectives of the blended payment and a pragmatic judgement about feasibility.
   • For example, where a variable payment is not feasible due to a lack of activity or cost data, a financial risk sharing arrangement may be more appropriate.

3. A risk sharing element, either activity-based or financial

4. An outcomes-based payment

14. In the 2019/20 NTPS, blended payment was established as the default payment approach for emergency care and adult mental health services. The emergency care blended payment involved fixed and variable elements, while
the mental health model also included an outcomes-based element and an optional risk share.

15. The blended payment model developed with ICSs involves an intelligent fixed payment, with system-wide risk share and outcomes elements and a variable element to share risk of activity being different from plan. However, some areas have chosen to use a simpler payment model, involving a fixed payment and some form of financial risk share. Any changes to ‘default’ reimbursement models for particular services should not stand in the way of local systems choosing to move faster towards population-orientated payment models across all areas of care, using the tariff’s rules for local payment approaches.²

16. Regardless of the payment approach used, a rigorous, transparent approach to coding, counting and costing activity will continue to be essential. This allows activity data to be analysed alongside data on needs and outcomes, which supports continuous improvements in efficiency and effective use of available resources.

17. For the 2020/21 NTPS, we initially considered proposing a move to a blended payment approach for outpatient attendances, maternity and adult critical care services. We received a lot of feedback on potential blended payments for these services areas, particularly through the September workshops and webinars. We have revised the potential blended payment models in light of this feedback. For adult critical care, we now feel that it may be more appropriate to pilot the approach during 2020/21.

Blended payments being considered for 2020/21

Outpatients

18. Changing the way outpatient services are delivered is one of the key goals of the NHS Long Term Plan. The plan pledges to ‘redesign services so that over the next five years patients will be able to avoid up to a third of face-to-face outpatient visits, removing the need for up to 30 million outpatient visits a year.’ Every patient will also be able to, where appropriate, opt for a ‘virtual’ outpatient appointment.

² For details of the tariff rules on local variations, see section 6 of the 2019/20 NTPS.
19. We have been working with providers and commissioners, as well as the NHS England and NHS Improvement Outpatient Transformation Programme, to understand how the way outpatient attendances are paid for could support or hinder this goal. We feel that the payment system for outpatients must:

- be an enabler for systems who are looking to redesign their care models and transform their services
- be simple and easy to implement, reducing the administrative burden the payment system places on providers and commissioners.

20. With this in mind, we are considering moving to a blended payment system centred around the journey of patients through the system. Reforming payments for outpatient services would be a first step towards paying for meaningful groupings of activities across settings to allow services to be designed around the journey of patients through a system rather than forcing patients to fit a system. This blended payment for outpatients would potentially be implemented in two stages:

- For the 2020/21 NTPS, reimbursement of all outpatient attendances would move to a blended payment system.
- In subsequent tariffs, starting in April 2021, activity would start to be grouped and paid for, either by specialty or some other grouping that is meaningful for both clinicians and patients. We are considering starting with ophthalmology, dermatology and rheumatology as they are specialties with high volumes of activity and well established pathways.

21. Outpatient attendance reimbursement has been largely unchanged since being introduced across the NHS in 2005/6. Since then there has been a shift in how care is delivered to patients, with more emphasis on trying to shift care out of the acute setting, the increased use of one stop shops and multidisciplinary appointments, the introduction of advice and guidance services, the introduction of virtual clinics and the move to offering patients more digital services.

22. Compared to the current episodic payment system, a blended payment approach could better support the way outpatient services are being delivered and how they will evolve to support the NHS Long Term Plan. A blended payment approach would place more emphasis on system planning and
working and less emphasis on individual units of activity delivered by consultants in a face-to-face setting, which can create barriers to shifting care to non-acute settings.

23. At the September tariff engagement workshops, many attendees were concerned by the potential complexity of the blended payment for outpatients that was presented. There were also a number of questions about whether the payment approach would successfully support the Long Term Plan goals.

24. We have reviewed the approach in light of this feedback and, for 2020/21, we are considering the following design for a blended approach for outpatient attendances:

- The largest element of the blended payment would be an intelligent fixed payment.
  - This would be calculated based on locally agreed expected activity volumes and nationally published prices.
  - It would include all services that are currently nationally priced, as well as agreed local prices for other activity, supported by the non-mandatory prices for non-face-to-face activity.
  - We would recommend that video consultations should have the same price as face-to-face consultations.
  - The fixed payment would also include the set up and running costs of advice and guidance services, which would need to be agreed between provider and commissioner.

- A risk sharing agreement could help support agreement of the fixed element. The risk share would mean that if actual activity was materially different to that assumed when setting the fixed payment, the financial impact would be shared according to a locally pre-determined arrangement.
  - The risk share would not reimburse additional activity as a pure activity-based variable element; rather, it would recognise that there may be either cost or performance implications if service demand increases outside of the direct control of the provider.
  - The risk share could be constructed in a number of ways and one option is that it could be based on the number of excess GP referrals made into

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3 For details, see the webinar [Blended payment for outpatient attendances](#).
the provider, which have been deemed appropriate via an advice and
guidance service.
– To avoid inappropriate discharges back to primary care for re-referral, we
could provide guidance on using existing consultant-to-consultant referral
rates and first to follow up ratios as a baseline.
• To drive the vision for outpatient services set out in the Long Term Plan, an
outcomes based element could also be incorporated into the blended
payment. This would align to the metrics being developed by the Outpatient
Transformation Programme to support the Long Term Plan commitment to
remove one third of face-to-face outpatient attendances.

25. We would expect the blended payment to apply to outpatient attendances
commissioned by clinical commissioning groups (CCGs) and those
commissioned by NHS England Specialised Commissioning. However, it
would not apply to diagnostic imaging services or outpatient procedures. We
are considering proposing a contract value threshold of £4m, below which the
existing episodic payment approach would continue to apply.

26. We will continue working in parallel to develop some patient-pathway-specific
blended payment models. These would allow payment to cover the patient
journey rather than be care setting specific. We envisage that some pathway
payments would be proposed for the tariff due to come into effect in April
2021, with a wider rollout in future tariffs.

Maternity

27. In 2016, the Better Births report recommended reviewing the maternity
pathway payment approach. It stated that: ‘the future payment system should
be flexible and allow for localities to decide, on the basis of local
circumstances, the payment structure which will best enable the money to flow
locally and improve care’. The report also said that the payment system needs
to ‘support providers to work together across a Local Maternity System’ (LMS)
and to ‘reflect the different cost structures services have’.

28. The NHS Long Term Plan also set out objectives for maternity services that
the payment system needs to support.

29. We have been working with the maternity sector and the maternity
transformation board to consider alternatives to the current payment
approach. While system redesign has often been a higher initial priority, LMSs have been interested in how payment can better support maternity transformation. Based on our experience with blended payment in other areas of care, we believe that a blended payment approach for maternity services has the flexibility and potential to help systems to do the following:

- **Implement a system financial plan** at LMS level. By adopting a blended payment approach the system can better distribute available resources to support the overall system plan.
- **Materially reduce the provider-to-provider payments** that result from the current payment approach, and the associated administrative burden, by identifying historic patterns of patient flows around the LMS and taking this into account when determining the funding of each provider within the LMS.
- **Support delivery of other Better Births objectives**, such as accelerating the implementation of continuity of carer by recognising short-term increases in costs needed to deliver longer-term savings and safer care.

30. During the September engagement workshops and the maternity webinar, we presented a potential blended payment approach for maternity services. Attendees strongly supported reducing provider-to-provider payments, so long as this did not just mean moving the problem elsewhere in the system.

31. We have carefully considered the feedback from the workshops and, for 2020/21, we are considering proposing the following blended approach for maternity services:

- **An intelligent fixed payment.**
  - This would be based on the nationally published maternity pathway prices and locally agreed projected activity for each provider.
  - There would then be an adjustment, up or down, based on the historic net income flows between other providers in the LMS.
  - Any costs associated with activity expected to be delivered by providers outside the LMS would be held by commissioners. This should remove the need for in-year provider-to-provider payments within the LMS.
  - Any system initiatives that are part of the LMS plan but not covered by current activity or prices, for example specific programmes to try and

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4 For details, see the webinar [Blended payment for maternity services](#).
address inequalities, should be considered in finalising the intelligent fixed payment.
– This should mean the value of the fixed payment is aligned with the LMS plan, giving greater certainty to commissioners and providers and allowing a better environment for integrated working and innovation.

• A risk sharing element would share the financial impact of risks materialising, for example more or fewer complex cases than anticipated, or shifts in where women chose to receive their care, compared with assumptions in the system plan. This should support an environment, and governance arrangements, for effectively managing emerging risks in the system due to material variations from the system plan.

• An outcome-based element would be used to bind all system partners to the delivery of LMS priorities and population outcomes, specifically referencing the targets set out in the Long Term Plan. We are considering setting principles and a framework for the outcomes element, with an initial focus on process measures.

Adult critical care services

32. As all sustainability and transformation partnerships (STPs) move towards becoming ICSs by April 2021, it may be appropriate to adopt a blended payment approach for adult critical care services (ACC). The blended payment would be based on a consideration of the required level of ACC capacity and funding for the population served, and should also support initiatives aimed at expediting recovery and reducing the need for critical care.

33. During the September engagement workshops and the ACC webinar, we discussed an approach to blended payment for ACC. This involved:

• an intelligent fixed payment to cover the estimated costs of critical care capacity to support all patients up to and including the level of needing one organ supported (typically high dependency unit (HDU) level care)
• a variable payment to cover the incremental costs of two or more organs supported
• the potential to develop outcomes-based payments.

For details, see the webinar Blended payment for adult critical care.
34. We received a lot of feedback on this potential approach. There was general agreement that the current payment approach did not support service innovations that reduce the avoidable use of critical care, or that expedite recovery and timely discharge – a central part of the case for change. However, a number of concerns were raised, particularly regarding the complexity of current commissioning arrangements and the related difficulty of locally agreeing required ACC capacity.

35. Following this feedback, and discussions with the adult critical care clinical reference group and operational delivery networks, we are now considering piloting a more streamlined blended payment approach during 2020/21. This approach would focus on fixed and outcomes-based payment elements, potentially with an element to share risk across system partners. We are considering producing indicative non-mandatory benchmark prices to support development and implementation of the pilot ACC blended payment approach.

36. We intend to propose a blended payment for ACC as part of our consultation on the 2021 NTPS. As well as allowing the model to be informed by learning from the pilot, this would also allow time for ACC coordinating commissioner arrangements to be developed. These would be intended to greatly simplify ACC commissioning – and, therefore, the process for locally agreeing required critical care capacity.

**Emergency care and mental health**

37. We do not anticipate making significant changes to the blended payments for emergency care or mental health services for the 2020/21 NTPS. However, we are considering updating the guidance to support implementation, following feedback. We are particularly looking to clarify the approach to reimbursing best practice tariffs (BPTs) within the blended payment, as well as developing worked examples of how the blended payment could be implemented.

38. In the longer term, we are considering changing the design of the emergency care and mental health blended payments to focus more on outcomes-based elements that support Long Term Plan objectives, rather than activity-based variable elements.
3. Other policies being considered

Market forces factor

39. The market forces factor (MFF) estimates the unavoidable cost differences between healthcare providers. Each NHS provider is assigned an individual MFF value. MFF values adjust prices and commissioner allocations.

40. The MFF is made up of six component indices: staff (non-medical and dental); staff (medical and dental); buildings; land; business rates; other. These are combined into an overall MFF index, weighted by national expenditure. The ‘other’ component is assumed not to vary unavoidably between providers.

41. In setting the 2019/20 NTPS the method and data used to calculate MFF values were comprehensively reviewed and updated. We received feedback that suggested further changes to the MFF method may be warranted. Based on this feedback we are undertaking the following work. However, not all of this is likely to be finalised in time to propose changes for the 2020/21 NTPS.

* We are reviewing the elements of the ‘other’ component and whether the weighting of the MFF components should be changed. For example, expenditure on operating leases might be more appropriately included in the buildings component, or expenditure on outsourced services (such as facilities management) in the staff component.

* We are working on a review of the land index and assessing whether travel to work areas (TTWAs), used in the staff index, adequately reflect the local labour market in all areas.

42. We are also considering whether it would be appropriate to update the data used to calculate MFF values. The updates in 2019/20 involved significant changes as much of the data had not been updated for almost ten years. We want to avoid similar issues in the future, without causing unnecessary instability. The impact of a data update at this stage would be relatively small, but would need to be balanced against considerations like planning certainty.
Setting proposed prices

Rollover of price relativities

43. Calculation of tariff prices is a complex process. Updating the activity and cost data that underpin the calculations can introduce significant volatility and shifts in individual price levels between years. While the price setting method limits this volatility, there can still be significant differences between years.

44. When the 2017/19 NTPS was set for two years, the additional certainty this gave was welcomed and many stakeholders reported that this supported planning. In addition, the NHS Long Term Plan sets out the intention to further reform the payment system and encourage the wider adoption of blended payment approaches. In this context, we felt it would be appropriate to limit the extent of any changes to price relativities to enable more focus on these other developments. Therefore, we are intending to propose rolling over the price relativities used in the 2019/20 NTPS.

45. The 2020/21 NTPS prices would not be the same as those for 2019/20, and adjustments including inflation and efficiency would be applied. The Long Term Plan Implementation Framework included assumptions for inflation and efficiency and we will review these as part of setting the price levels we propose in the statutory consultation on the 2020/21 NTPS.

46. We received a number of responses to our call for feedback on the 2019/20 price relativities in June and July 2019. We have carefully considered these responses and worked with NHS Digital National Casemix Office expert working groups (EWGs) to review the price relativities and how to respond.

47. We are considering manually adjusting prices in exceptional cases where prices are clearly wrong and/or need updating, based upon the advice provided by the clinical advisory groups such as the EWGs.

48. For example, we will be proposing a manual adjustment to uplift prices for sleep disorders grouping to AA43A and AA43B. The prices were inappropriately low due to an anomaly in the reference costs from a single provider performing the largest volume of activity against these two HRGs. To fund the adjustment, there is likely to be a slight decrease in other prices in the subchapter.
49. We are still seeking clinical advice on some other price relativities where potential issues have been raised by stakeholders. This may lead to further manual adjustments being proposed in the statutory consultation.

50. We have received a lot of feedback about prices for glaucoma and cataract surgery. We have been working with NHS Digital to adjust the grouping of these procedures so they will be grouped to a higher priced HRG.

**Centralised procurement**

51. For the 2019/20 NTPS, the total amount reimbursed through the national tariff was reduced by around £204 million to reflect the new arrangements for the NHS Supply Chain. This adjustment was intended to reflect the efficient costs of Supply Chain Coordination Limited (SCCL) relating to services covered by the NTPS, and not those that are covered by other SCCL income streams (such as rebates from suppliers, customer income from NHS England and income from customers not providing tariff services).

52. This compensation for services relating to NHS healthcare, performed by SCCL in the public interest, has enabled mark-ups on prices to be removed, lowering procurement prices for trusts and improving transparency of pricing.

53. We currently do not have a final estimate of SCCL’s overhead costs (and other income streams) for 2020/21. However, we are considering making no further adjustments to the tariff, regardless of any increase in overhead costs.

**Specialist top-ups**

54. National tariff prices are calculated based on average costs. Therefore, they do not take into account cost differences that arise because some providers serve patients with more complex needs. Top-up payments for some specialist services recognise these differences and aim 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.

55. Following the move to prescribed specialised services (PSS) designation of specialised services, the services and providers that qualify for a top up were changed in the 2017/19 NTPS. If the resulting changes had been applied in

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For details, see section 5.2.1 of the [2019/20 National Tariff Payment System](#).
one step this would have created a significant amount of revenue instability. It was therefore decided to move 25% of the way towards the new reimbursement levels as part of a four-stage transition path.

56. In the 2019/20 NTPS we changed the amounts payed as top-ups to reflect updated PSS identification rules (IR), hierarchy and provider eligibility lists. We also implemented the next step of the transition path, moving 50% towards the new reimbursement levels.

57. We are considering whether it would be appropriate to make further changes for the 2020/21 NTPS. However, we are likely to propose keeping the 2019/20 transition level (50%) and changing the PSS top up payment rates to reflect updated PSS flags and recent activity data (2018/19 Hospital Episode Statistics – HES).

58. We are working with NHS Digital on potential technical changes to top-up payment areas that might be included in the PSS IR 2020/21 planning and operational tools.

59. We are looking at how the tariff could more effectively support providers serving patients with more complex care needs. The outcome of this work may have an impact on the specialist top-ups policy in future tariffs.

60. We are also considering changes to top-up payments for specialised orthopaedic services. This would support the clinical re-design of services, led by Getting It Right First Time (GIRFT) and the Trauma Programme of Care team, towards a hub and spoke model. We are interested in testing the approach for knee revision surgery in 2020/21. If this is successful, we would then consider proposing to roll it out into other specialised areas of orthopaedics from 2021/22. The British Orthopaedic Association (BOA) and the orthopaedics EWG have fully endorsed this change, which is in line with our commitment to address issues related to orthopaedics in previous tariffs.

61. The potential payment approach for specialised orthopaedic services would be based on the following key principles:

- A hub and spoke network of specialist providers leading local systems to support the delivery of best practice clinical standards defined by GIRFT.
• Funding a multidisciplinary (MDT) referral service, led by GIRFT and managed by the specialist centres. This service will determine which cases are managed by the specialist centres’ regional hubs and which are undertaken by local hospitals (the spokes).
• A two-part payment system for activity – a core payment and a complexity payment.
• Alignment with the general direction of travel of devolving activity to local commissioning systems (CCGs/STPs/ICSs).
• Using existing data flows (where possible) to support the commissioning process.

Chemotherapy services

62. Payment for chemotherapy services currently involves two elements:

• Chemotherapy delivery, which is covered by national currencies under HRG subchapter SB. Most of these HRGs have national prices in the tariff.
• Chemotherapy procurement, which does not have national currencies or prices.

63. Chemotherapy procurement involves by far the highest costs, which are increasing year on year. However, chemotherapy procurement is reimbursed using several different methodologies, including regimen bandings, making it difficult to fully understand the true cost of the service. As such, the current reimbursement methodology needs reform and standardisation.

64. NHS England Specialised Commissioning has set out an intention to move to a consistent approach across all providers, based on ‘pass-through’ arrangements. However, there remains a 10-12 large cancer centres that continue to charge based on the procurement regimen bandings.

65. We are working with Specialised Commissioning to understand how the tariff could best support delivery of chemotherapy services. For the 2020/21 NTPS, we are considering the following changes:

• Incorporating the cost of chemotherapy supportive drugs into the chemotherapy delivery tariffs (HRGs SB11Z to SB15Z). Bringing the cost of supportive drugs into tariff prices would remove the need for providers to
separately invoice for these items but would not affect commissioning responsibility. This change is intended to be cost neutral and, if required, there would be a quarterly, six-monthly or annual reconciliation at an individual provider level. This would also inform the final adjustment value to be used in 2021/22.

- Retiring the regimens as a basis of reimbursement for chemotherapy procurement, with all chemotherapy drugs reimbursed on a pass-through arrangement either in line with the high cost drug list or a new chemotherapy drug list.

66. In addition, we are considering signalling the intention for a baseline data collection exercise during 2020/21 to gain an understanding of current charging methodologies for aseptic units.

High cost exclusions

67. In the development of each national tariff, we look to identify potential changes to the high cost drugs, devices and procedures lists through a ‘horizon scanning’ exercise for drugs and through nominations submitted via a web portal for both drugs and devices.

68. As a result, we are considering the following proposals for the 2020/21 NTPS.

High cost drugs

69. Following the horizon scanning and nominations process and discussions with the high cost drugs steering group, we are considering adding 34 drugs to the list and removing five. See the Appendix for a full list of these items.

70. It has been suggested that Anidulafungin, Botulinum Toxin, Caspofungin, Isavuconazole, Micafungin, Posaconazole and Voriconazole should be removed from the high cost list. We are working to determine whether data is available that would enable us to remove these drugs and add costs back into relevant national tariff prices.

High cost devices

71. We are considering adding one device to the high cost list – sutureless aortic heart valves/rapid deployment aortic heart valve replacement.
72. We are also considering re-naming the existing exclusion category ‘Deep brain, vagal, sacral, spinal cord and occipital nerve stimulators’ to include the term ‘neurostimulators’.

73. A number of products are currently covered by Innovation and Technology Tariffs/Payments (ITT/P)\(^7\) which are centrally funded. We are exploring options to move to a local funding approach for these products in 2020/21. In considering options, we are mindful of the need to ensure providers can be reimbursed appropriately for the costs of these innovations, and that the payment system supports the take-up of these products.

74. We are also considering how to incentivise the national spread of some digital products supported by the ITP that have been shown to be beneficial. See ‘Other areas of work’ for more details.

**High cost procedures**

75. We are working with NHS England Specialised Commissioning colleagues to determine how the national tariff can support revised commissioning and reimbursement arrangements for cancer genomic testing from 2020/21. We are seeking to identify the costs associated with these tests and how these costs might be removed from national tariff prices.

**Best practice tariffs**

76. As part of the development of each new tariff, we review best practice tariffs (BPTs) to ensure they are fit for purpose and whether there are any new areas where a BPT might support improvements. For the 2020/21 NTPS we are considering proposing a new BPT for adult asthma care and updating existing BPTs including acute stroke care, day case and fragility hip fracture.

77. We are also reviewing the achievement rates of existing BPTs and ensuring that they remain aligned with relevant clinical guidelines. Any potential changes as a result will be set out in the statutory consultation on the 2020/21 NTPS.

New BPT: Adult asthma care

78. The adult asthma BPT would be based on the COPD BPT, which was introduced in the 2017/19 NTPS. It would be made up of the following two elements:

- Specialist review within 24 hours of acute admission
- Use of a discharge bundle.

79. The discharge bundle must include the first three items listed below. The other two other elements are recommended but not mandatory:

- Personalised action plan issued or reviewed (mandatory)
- Inhaler technique (including maintenance medication review) (mandatory)
- Smoking cessation advice, referral or support (mandatory)
- Asthma triggers where relevant (recommended)
- Specialist review requested within four weeks of discharge (recommended).

80. The data flow for the adult asthma BPT would be the National COPD & Asthma Program (NCAP) RCP audit. They will publish the trust level achievement rates, mirroring the COPD BPT reports they currently produce.

81. The current COPD BPT would also be updated to align with the potential adult asthma BPT.

Update BPT: Acute stroke care

82. Following discussions with NHS England and NHS Improvement’s medical directorate, we are considering changing the acute stroke care BPT criteria.

83. This would involve reducing the target time for brain scan on arrival at hospital from 12 hours to one hour and adding a new requirement for assessment by a stroke specialist clinician within this one-hour time window.

84. The changes would align with the planned urgent care standards, currently being trialled, which include a one-hour package of care for stroke.
Update BPT: Day case

85. We are considering amending the day case BPT to reflect achievement rates using 2018/19 data and the recently published British Association of Day Surgery directory 6th edition recommended day case rates. Details of the potential changes are set out in the Appendix.

86. We have also reviewed the day case scenarios with clinical experts. We are considering retiring scenarios where the recommended target rate has been achieved and adding some new scenarios. See Appendix for details.

Update BPT: Fragility hip fracture

87. Following a request from the National Clinical Director, we are considering extending the scope of the fragility hip fracture BPT to include all femoral fractures and distal fractures. This would help reduce the wide variation in care and poor outcomes of patients with a fracture of the femur that is not a ‘neck’ of femur fracture.

88. Changes to the National Hip Fracture Database would be required to support the additional recording and reporting arrangements to support the inclusion of the extended cohort of patients.

89. We do not anticipate changing the BPT pathway criteria requirements. However, to reflect the updated scope, the name of the BPT would change to the ‘Fragility fracture of hip and femur BPT’.

Update BPT: Major Trauma

90. Following a request from the National Clinical Director, we are considering amending one of the Level 2 criteria for the major trauma BPT. The criteria requires that tranexamic acid is administered within one hour of arrival at scene (or arrival at the major trauma centre for self-presentations) for patients with at least one injury associated with significant bleeding. We are considering broadening the criteria to include patients with a Glasgow Coma Scale of 13 or less with a significant head injury.
91. This potential change has been prompted by the findings of an international study\(^8\) which indicates that an expansion in the use of tranexamic acid in trauma can help save lives and improve recovery.

**Other areas of work**

92. Given the proposed rollover of price relativities, we would continue using the 2016/17 reference costs version of the HRG4+ currency design to set national prices. We would make some minor updates where necessary.

93. We are considering how the tariff may be able to incentivise the use of artificial intelligence (AI), machine learning and digital products. In particular, we are considering proposing the following:

- Setting prices for non-invasive technologies for estimating fractional flow reserve, such as HeartFlow,\(^9\) based on a nationally negotiated cost. This could then be added to the high cost devices list.
- Supporting outpatient scheduling tools by trialling a range of potential reimbursement models.

94. We are considering producing non-mandatory benchmark prices for neonatal critical care and IAPT services. These would be published alongside the statutory consultation and would be intended as a starting point for providers and commissioners to discuss and agree local prices for these services.

95. We are also working towards using patient-level costs (known as PLICS) to set tariff prices, rather than reference costs, for the 2021 NTPS and beyond. This follows the mandation of patient-level costing for the acute sector from 2018/19, with other sectors expected to follow, and the replacement of reference costs with the single national cost collection.

96. We are also considering how the tariff can be used to incentivise the reduction in the NHS’s carbon footprint, consistent with the UK’s climate adaptation targets.

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\(^8\) [www.thelancet.com/journals/lancet/article/PIIS0140-6736(19)32233-0/fulltext](www.thelancet.com/journals/lancet/article/PIIS0140-6736(19)32233-0/fulltext)

\(^9\) Heartflow produces a 3-D image of the heart and cardiac blood vessels, reducing the need for diagnostic angiograms. It has been supported by the ITP and will be eligible for the Medtech Funding Mandate from April 2020.
4. How to provide feedback

97. We have set up an online survey\textsuperscript{10} to gather your feedback on the areas of work discussed in this document. A Word version of the survey questions is available to download from the survey home page to help you compile a response. However, all responses should be submitted via the online survey, not via email.

98. The deadline for feedback is the end of 18 November 2019.

99. We will consider all feedback carefully and launch the statutory consultation on our proposals for the 2020/21 NTPS as soon as possible after the UK general election.

100. If you have any questions, please contact pricing@improvement.nhs.uk.

\textsuperscript{10} https://engage.improvement.nhs.uk/pricing-and-costing/2020-tariff-engagement
Potential changes to day case BPT achievement rates

As described in section 3, we are considering amending the day case BPT to reflect achievement rates using 2018/19 data and the recently published British Association of Day Surgery directory 6th edition recommended day case rates.

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>Breast surgery</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Axillary clearance</td>
<td>⇨ 95%</td>
<td>↑ 45%</td>
<td>↑ 32%</td>
</tr>
<tr>
<td>Simple mastectomy</td>
<td>↑ 75%</td>
<td>↑ 35%</td>
<td>↑ 23%</td>
</tr>
<tr>
<td><strong>Ear, nose and throat (ENT)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FESS endoscopic uncincetomy, anterior and posterior ethmoidectomy</td>
<td>↑ 95%</td>
<td>↑ 90%</td>
<td>↑ 76%</td>
</tr>
<tr>
<td>Tonsillectomy (± adenoidectomy) – Children</td>
<td>↑ 90%</td>
<td>↑ 70%</td>
<td>↑ 55%</td>
</tr>
<tr>
<td>Tympanoplasty</td>
<td>⇨ 95%</td>
<td>↑ 90%</td>
<td>↑ 78%</td>
</tr>
<tr>
<td><strong>Gynaecology</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anterior or posterior colporrhaphy</td>
<td>↑ 75%</td>
<td>↑ 35%</td>
<td>↑ 21%</td>
</tr>
<tr>
<td><strong>Head and neck</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excision of lesion of parathyroids</td>
<td>↑ 60%</td>
<td>↑ 35%</td>
<td>↑ 23%</td>
</tr>
<tr>
<td><strong>Orthopaedic surgery</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Autograft anterior cruciate ligament reconstruction</td>
<td>⇨ 90%</td>
<td>↑ 55%</td>
<td>↑ 45%</td>
</tr>
<tr>
<td>Posterior excision of lumbar disc prolapse including microdiscectomy</td>
<td>30%</td>
<td>↑ 25%</td>
<td>↑ 15%</td>
</tr>
<tr>
<td><strong>Urology</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cystostomy and insertion of suprapubic tube into bladder</td>
<td>⇨ 80%, .</td>
<td>↑ 70%</td>
<td>↑ 59%</td>
</tr>
<tr>
<td>Endoscopic insertion of prosthesis into ureter</td>
<td>⇨ 90%</td>
<td>↑ 75%</td>
<td>↑ 64%</td>
</tr>
<tr>
<td>Endoscopic resection/destruction of lesion of bladder</td>
<td>⇨ 60%</td>
<td>↑ 30%</td>
<td>↑ 18%</td>
</tr>
<tr>
<td>Optical urethrotomy</td>
<td>⇨ 95%</td>
<td>↑ 75%</td>
<td>↑ 63%</td>
</tr>
</tbody>
</table>

**Key**

⇨ no change to previously published BADS rate / national average
↑ increase in previously published BADS rate / national average
Potential changes to day case BPT scenarios

Scenarios considered for retirement from day case BPT

- Tonsillectomy – Adults
- Polypectomy of internal nose
- Excision biopsy of lymph node for diagnosis (inguinal, axillary)
- Repair of incisional hernia (merged)
- Operations to manage female incontinence
- Hemithyroidectomy, lobectomy, partial thyroidectomy
- Dacryocysto - rhinostomy including insertion of tube
- Ureteroscopic extraction of calculus of ureter
- Creation of arteriovenous fistula for dialysis
- Endoscopic resection of prostate (transurethral resection – TUR) and Resection of prostate by laser – retiring the merged scenario and replacing with two separate scenarios listed below.

Scenarios considered for addition to day case BPT

- Endoscopic laser fragmentation of calculus of kidney
- Endoscopic resection of prostate (transurethral resection – TUR)
- Resection of prostate by laser.
Potential changes to the high cost drugs list

The following tables give details of the drugs we are considering adding and removing to the high cost drugs list for the 2020/21 NTPS.

We remove drugs from the high cost list for a number of reasons, such as if they are no longer in use or are available as ‘generic’ and so are no longer high cost. A key part of the process before we remove any drugs from the list is to consider the potential impact. For example, if we propose to remove a drug from the list, we need to establish which HRG prices would need to increase, as providers will be reimbursed for using the drugs through those tariff prices. If we can’t determine which HRG prices we need to increase in order to cover drugs costs, then invariably we recommend that the drugs remains on the high cost list and so subject to separate reimbursement. This avoids providers stopping using a drug because they believe they would not be appropriately reimbursed via tariff prices.

Drugs being considered for addition to the high cost list

<table>
<thead>
<tr>
<th>Drug name</th>
<th>Drug name</th>
<th>Drug name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cilofexor</td>
<td>Icosabutate</td>
<td>Risdiplam</td>
</tr>
<tr>
<td>Ciraparantag</td>
<td>Imlifidase</td>
<td>Selumetinib</td>
</tr>
<tr>
<td>Elafibranor</td>
<td>Levosimendan</td>
<td>Setrurusumab</td>
</tr>
<tr>
<td>Elamipretide</td>
<td>Lumasiran</td>
<td>Sutimlimab</td>
</tr>
<tr>
<td>Elapegademase-lvlr</td>
<td>Lumicitabine</td>
<td>Teprasiran</td>
</tr>
<tr>
<td>Etrasismod</td>
<td>MEDI2452</td>
<td>Teprotumumab</td>
</tr>
<tr>
<td>Evinacumab</td>
<td>Mirikizumab</td>
<td>Tezepelumab</td>
</tr>
<tr>
<td>Fedratinib</td>
<td>Olipudase alfa</td>
<td>Tipelukast</td>
</tr>
<tr>
<td>Fenfluramine</td>
<td>Olokizumab</td>
<td>Triamcinolone acetonide</td>
</tr>
<tr>
<td>Garetosmab</td>
<td>Palovarotene</td>
<td>Vorolanib</td>
</tr>
<tr>
<td>Gosuranemab</td>
<td>Piclidenoson</td>
<td></td>
</tr>
<tr>
<td>Guadecitabine</td>
<td>Platelet lysate-based</td>
<td></td>
</tr>
<tr>
<td></td>
<td>therapy</td>
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</tr>
</tbody>
</table>
Drugs being considered for removal from the high cost list

<table>
<thead>
<tr>
<th>Drug name</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Boceprevir</td>
<td>Simeprevir</td>
<td>Winfuran (KP1461)</td>
</tr>
<tr>
<td>Daclatasvir</td>
<td>Telaprevir</td>
<td></td>
</tr>
</tbody>
</table>