19 December 2019

on the day BRIEFING

NHS Providers

2020/21 national tariff payment system – formal consultation

NHS England and NHS Improvement (NHSE/I) have released the formal statutory consultation on the national tariff payment system (NTPS) for 2020/21. Alongside the consultation notice, there are a series of documents explaining the proposed changes. These documents follow a pre-engagement survey carried out in November 2019. The consultation is open now until 22 January 2020.

Documents published include, among others:

- Part A: 2020/21 national tariff payment system – a consultation notice
- Part B: proposed 2020/21 national tariff payment system
- Guidance on blended payments
- Guidance on maternity pathway payment
- Guide to the market forces factor
- 2020/21 NTPS impact assessment

NHS Providers will be responding formally to this consultation. We encourage trusts to respond to the consultation individually, and to provide feedback to us. If you have any questions on this briefing or our work in this area, please contact patrick.garratt@nhsproviders.org, david.williams@nhsproviders.org or adam.wright@nhsproviders.org.

Summary of proposals for the national tariff payment system

The main proposals set out in the NTPS consultation are as follows:

- Introducing blended payment approaches for outpatient attendances and maternity services, following the roll out of blended models for urgent and emergency care (UEC) and mental health services in the 2019/20 NTPS.
- NHSE/I will pilot the blended payment model for adult critical care (ACC) for 2020/21, rather than making a blended system the default.
- The tariff will once again be set for one year.

- The cost uplift factor will be set at 2.5%. Included within this, the uplift factor for pay will be set at 2.9%.
- The efficiency factor will remain at 1.1%.
- Price relativities will be rolled over from 2019/20.
- The 2020/21 cost base will be kept equal to the revenue that would be received under 2019/20 prices.
- While outpatient attendances, emergency care and maternity will not be subject to mandatory national prices, the cost uplift factor will still be applied to the calculation of unit prices for these services.
- NHSE/I are not planning to make any further transfers of funding from CQUIN or the financial recovery fund for 2020/21.
- Following the adjustment made to the 2019/20 NTPS, when the tariff was topsliced by £204m to fund the central procurement body, Supply Chain Coordination Limited (SCCL), there will be no further adjustments made to the tariff regardless of any changes in SCCL's costs.
- There will be no more changes made to the market forces factor (MFF)'s underlying data and methodology for the 2020/21 tariff. Major revisions were made in 2019/20, which are being implemented over four years. This will reduce the total amount of money paid through the MFF, with compensating increases in national prices and prices for emergency care, outpatient attendances and maternity services. 2020/21 prices will rise by 0.38%,
- The prescribed specialised services (PSS) identification rules, hierarchy and provider eligibility lists will be updated. The transition path introduced in the 2017/19 NTPS will be paused, and a new payment approach will be piloted for specialist orthopaedic services.
- A new category of listed products – covered by the innovation and technology tariff /innovation and technology payment – will sit alongside the high cost drugs and devices lists.

Financial impact of changes

- The average increase in tariff revenue for acute providers as a percentage of 2018/19 operating revenue is 1.1%. 63 acute trusts will see an increase above the average.
- The impact on tariff revenue across the acute sector will range from 0% to 3%.
- Tariff revenue will rise 0.1 % for non-acute providers, 0.7% for specialist trusts, and 0.9% for teaching providers.
- The average year on year increase in tariff revenue for sustainability and transformation partnerships (STPs) will be 0.95%. The rise in tariff revenue for individual STPs will range from 0.5% to 1.4%.
- Applying new MFF factors in 2020/21 means there will be a reduction in commissioner spend compared to the retention of the 2019/20 values. The reduction of £138m paid through the MFF will be transferred through to an increase in core prices.

Blended payments

Following the introduction of blended payments for UEC and mental health services in 2019/20, NHSE/I will establish blended models for outpatient attendances and maternity services for 2020/21. NHSE/I believe these new blended payment systems will:

- support a more effective approach to resource and capacity planning to improve quality of care and health outcomes;
- provide shared incentives for commissioners and providers across a local system 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.

The blended payment model is not a single approach, but instead is a framework that can be adapted. It consists of:

- A fixed payment, based on activity and cost forecasts;
- A quality or outcomes based element;
- An element sharing financial or activity-based risks between provider and commissioner;
- And a variable payment, which is attached to activity levels.

Following feedback on blended payment proposals in autumn 2019, NHSE/I have decided to delay introducing blended payments for adult critical care. Instead, it will pilot a streamlined blended payment approach during 2020/21.

Guidelines have been issued by NHSE/I which detail how providers can agree activity levels within the scope of the blended payment agreement. This follows concerns expressed in the pre-engagement survey that there was a lack of worked examples in the guidance to support implementation.

The outcomes based elements within a blended system are intended to:

- create incentives for a focus on patient outcomes, rather than inputs/activities;
- signal that patient activities are a priority for all system partners;
- mitigate the risk that fixed payments encourage rationing of care or reduce the quality of care.

There was a clear steer from the tariff engagement document feedback that outcomes should be locally determined. In the separate blended payments guidance document, NHSE/I recognise the move to locally-developed quality- or outcomes-based approaches is unlikely to occur during the first year of implementation.

Blended model for outpatients

Blended payments will become the national default reimbursement model for outpatient attendances. This will involve a fixed payment, a locally determined quality- or outcomes-based element, and an optional risk sharing element.

To determine the fixed element, activity levels are to be agreed between commissioner and provider; prices are then determined for activity, and agreement over reimbursement is later agreed upon.

Currently, the outpatients blended model relates more to the quality element than it does to outcomes. Examples of the quality element include the response time to requests and how these compare to what was agreed, or the number of requests received from GPs and whether this is significantly different from what was planned.

A threshold of £4m for the introduction of the blended approach will be set. This should capture roughly 86% of CCG activity by value, but leave 80% of contracts out of scope, which should in theory minimise the administrative burden for low value contracts.

The introduction of blended payments removes outpatient attendances from the scope of national prices in 2020/21. However, agreement would still have to be reached over the amounts payable for outpatient attendances. Treatment function codes (TFCs) will be used as the basis for unit prices when calculating the blended payment for outpatients.

As the ambition is to develop patient-pathway-specific blended models, NHSE/I are proposing to introduce non-mandatory guidance and indicative prices for ophthalmology pathways in 2020/21. These pathways will be piloted and developed with ICSs.

Blended model for maternity services

NHSE/I have given two options for trusts providing maternity services:

- a blended payment approach, involving fixed, quality- or outcomes-based and optional risk-sharing elements;
- the maternity pathway payment, as in previous tariffs.

NHSE/I's intention for adopting blended payments for maternity services is to encourage the implementation of system financial plans; to reduce provider-to-provider payments, and to support the implementation of other Better Births objectives.

NHSE/I have recommended that the choice of payment approach is agreed on a local maternity system (LMS) level. While individual contracts will be agreed upon between an individual provider and

commissioner, system partners are being encouraged to share financial and activity information across LMSs to better support system planning.

Like emergency care, healthcare resources groups (HRGs) will be the basis of the unit prices used to calculate prices for maternity services. Alternatively, if HRG level data is not available, the fixed payment can be calculated using activity levels and prices for the maternity pathway.

The quality- or outcomes-based measures are expected to be linked to the Better Births programme and the long term plan, both of which support safer and more personalised care. Examples in the accompanying guidance for blended payments for quality- and outcomes-based measures include raising awareness of reduced fetal movement, reducing smoking in pregnancy, and the implementation of an LMS wide postnatal improvement plan.

Currency design and specification proposals

- The HRG4+ phase 3 currency design used for 2016/17 reference costs will be used to set national prices.
- Emergency care, outpatient attendances and maternity services will be excluded from the currencies for national prices.
- The chemotherapy procurement regimens list will be retired, and the cost of chemotherapy supportive drugs will be incorporated into chemotherapy delivery tariffs. The rationale for this is that bringing the cost of supportive drugs into tariff prices should remove the need for providers to separately invoice for these items. This action should be cost neutral.
- The high cost drugs list will be updated by adding 16 drugs and removing five drugs.
- All cancer genetic testing will be reimbursed outside of national tariff prices – this will remove £77.8m from the tariff.
- The rapid deployment aortic valve replacement/sutureless aortic heart valve will be added to the high cost devices list.

Tariff prices for 2020/21

- The tariff will be set for one year from 1 April 2020. NHSE/I have expressed its intention to set a longer tariff in the future.
- The 2020/21 NTPS will use the same cost and activity data to model prices used for the 2019/20 NTPS. Costs will therefore be based on 2016/17 reference costs, and activity will be based on 2016/17 hospital episode statistics and 2016/17 reference costs.
- The 2019/20 NTPS price relativities will be used again for 2020/21.
- Emergency care, maternity services and outpatient attendances will be included in price calculations and related adjustments, even though these services will not be subject to national prices.

- There are a number of cases where adjustment factors are being used to increase or decrease the amounts allocated to specific services. Cancer genetic testing will be funded by specialised commissioning; £12.9m will be allocated to specialised commissioning to fund complex knee revision surgery; £29.1m will be transferred from specialised commissioning to increase chemotherapy delivery prices and to include chemotherapy supportive drugs, and £15.7m will be moved out of a range of prices to increase postnatal maternity prices.
- Prices will be set for best practice tariffs in the same way as the 2019/20 NTPS.
- A new best practice tariff will be introduced for adult asthma care. This is intended to improve the proportion of patients who receive a specialist review of their care within 24 hours of an emergency admission and a discharge bundle before leaving hospital.
- Acute stroke, COPD, day-case procedures, fragility hip fracture and major trauma best practice tariffs have been updated.

Cost uplifts and efficiency factor

- The inflation cost uplift factor will be set at 2.5% for 2020/21.
- The efficiency factor will remain at 1.1% for 2020/21. NHSE/I maintains its estimate of 0.9% trend efficiency across the sector. It therefore considers that it is reasonable to keep the efficiency factor at its current level, based on evidence on catch-up potential and financial pressures.
- Even though outpatient attendances, UEC and maternity services will not be subject to mandatory national prices, the cost uplift factor will still be applied to the calculation of unit prices.

National variations

- 2020/21 will be the second year of a four-year transition for the MFF, which will reduce the total amount of money paid through the MFF, with compensating increases in national prices and prices for emergency care, outpatient attendances.
- The transition path for specialist top-up payment will be paused, following the move to prescribed specialised services (PSS) designation of specialist services. This means that the three services losing funding would continue to receive 50% of the difference, as in 2019/20.
- Local pricing rule 5 will be updated to create a new category of listed products to sit alongside the high cost drugs and devices list. The rule would also allow a reference price to be set for these listed products.

NHS Providers view

The 2020/21 tariff document demonstrates that blended payment models are increasingly being encouraged by NHSE/I as they attempt to phase out payment by activity. It is too early to make a clear

judgement on how effective and fair blended models across different services have proven, or will prove, to be. However, we welcome the fact that NHSE/I are clearly keen to respond to providers' concerns, particularly given the speed of the move away from payment by activity across a number of services

We note that no evaluation of blended payments across urgent and emergency care (UEC) and mental health services has yet been shared. It is therefore positive that NHSE/I have committed to undertake an evaluation of the blended payment approach for UEC after its first full year of implementation.

We are still keen to know how the fixed elements have been agreed, as well as the reasons for low or high levels of uptake of blended models across the acute and mental health sectors. The decision to adopt a blended model does not tell us if fixed element agreements were based on accurate activity forecasts. NHSE/I should therefore ensure they are aware of any difficulties faced by providers who adopt the blended model for outpatient attendances or maternity services, and particularly how the fixed element is agreed upon. We would also be interested in finding out more from providers about their experiences in agreeing fixed, risk-sharing and outcomes-based elements with commissioners.

NHS Providers is pleased that NHSE/I have responded to concerns from the provider sector about the pace of change for maternity services and adult critical care (ACC). This demonstrates a less rigid approach to implementation than in some of our previous engagement with them.

In our feedback to the November tariff engagement document, we raised our concerns about the lack of worked examples of blended payments available to providers, and recommended that more details be provided about what risk-sharing and outcomes-based measures could look like in practice. It is therefore helpful that a separate guidance document for blended payments has now been published. This provides clear examples about what quality-based measures look like in practice for maternity services. It is still however unclear at this point what outcomes-based measures will consist of for outpatients attendances.

It is encouraging that NHSE/I recognises the importance of determining outcomes on a local level – which providers fed back on during the engagement process – as well as highlighting the limitations of payment reform in delivering enhanced system working. In the guidance document on blended payments, NHSE/I notes that 'it is important that payment is seen as an enabler of local strategies and care models, rather than an end in itself'. Locally developed quality- or outcomes-based approaches will take time for system partners to agree to and develop. It is therefore vital that providers must first become confident in establishing desired outcomes with their commissioners before considering how outcomes and payment models are agreed at a system level. To ensure more joined-up care – such as ensuring greater integration with primary care, and supporting people with multiple and long term conditions – new payment models must accompany wider system reforms.

Although SCCL was established to reduce trusts' procurement costs, we note that we have still seen no evidence of the degree of savings made. Providers should not have had to fund the establishment of SCCL via a tariff topslice in the 2019/20, and it would be better if SCCL's running costs were funded via a mark-up on product prices. If SCCL is to be funded in this way however, it is positive that NHSE/I have listened to

the provider sector and decided to not increase the topslice, regardless of any increase in SCCL's overhead costs.

We are in favour of adopting a one-year tariff, given the speed of payment system changes, though we would eventually like to see the tariff set over a longer period of time to give providers more certainty over their baseline allocations. We are also pleased that the efficiency factor will remain at 1.1%, which seems reasonable given the sector trend efficiency figure is 0.9%.

We will be responding in full to the tariff consultation and look forward to engaging with providers, and working closely with NHSE/I as their new approach develops.

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