



# **2019/20 National Tariff Payment System**

**A joint publication by  
NHS England and NHS Improvement**

March 2019

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## Contents

1. Introduction .....	4
2. Scope of the 2019/20 National Tariff Payment System.....	6
2.1. Public health services .....	6
2.2. Primary care services .....	6
2.3. Personal health budgets .....	7
2.4. Integrated health and social care.....	8
2.5. Contractual incentives and sanctions .....	8
2.6. Devolved administrations .....	9
3. Currencies with national prices .....	11
3.1. Classification, grouping and currency .....	11
3.2. Currencies for which there are national prices.....	13
3.3. High cost drugs, devices and listed procedures .....	27
3.4. The innovation and technology tariff .....	28
4. Method for determining national prices .....	29
4.1. Overall approach .....	29
4.2. The method for setting prices .....	31
4.3. Managing model inputs .....	34
4.4. Manual adjustments .....	36
4.5. Volatility .....	38
4.6. Cost base .....	39
4.7. Cost uplifts and adjustments.....	40
4.8. Efficiency .....	49
4.9. Summary of cost adjustments .....	50
5. National variations to national prices .....	52
5.1. Variations to reflect regional cost differences: the market forces factor.....	53
5.2. Variations to reflect patient complexity .....	55
5.3. Variations to support new payment approaches.....	56
6. Locally determined prices .....	60
6.1. Principles applying to all local variations, local modifications and local prices .....	61
6.2. Local variations.....	63
6.3. Local modifications .....	65
6.4. Local prices .....	70
7. Rules for emergency care services .....	79
8. Payment rules .....	84
8.1. Billing and payment .....	84
8.2. Activity reporting .....	84

## 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.<sup>1</sup>
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**

Annex	Description
A	National tariff workbook (including national prices and prices to be used for emergency care)
B	Guidance on currencies with national prices
C	Guidance on currencies with no national price

<sup>1</sup> 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.

Annex	Description
D	Guidance on best practice tariffs
E	Technical guidance for mental health clusters
F	Models used to calculate prices
G	Guidance on locally determined prices

6. 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**

Title
A guide to the market forces factor
Non-mandatory prices
Guidance on blended payment for emergency care
Guidance on blended payment for mental health services
Guidance on maternity payment pathway

7. All annexes and supporting materials can be downloaded from the [NHS Improvement website](#).<sup>2</sup>
8. The national tariff forms part of a set of materials that inform planning and payment of healthcare services. Related materials include the [NHS Standard Contract](#)<sup>3</sup> and guidance on [Commissioning for Quality and Innovation \(CQUIN\)](#).<sup>4</sup>
9. If you have any questions about the national tariff, please contact [pricing@improvement.nhs.uk](mailto:pricing@improvement.nhs.uk)

<sup>2</sup> <https://improvement.nhs.uk/resources/national-tariff>

<sup>3</sup> [www.england.nhs.uk/nhs-standard-contract/](http://www.england.nhs.uk/nhs-standard-contract/)

<sup>4</sup> [www.england.nhs.uk/nhs-standard-contract/cquin/cquin-19-20/](http://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-19-20/)

## 2. Scope of the 2019/20 National Tariff Payment System

11. As set out in the [Health and Social Care Act 2012](#),<sup>5</sup> 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.
12. Various healthcare services are, however, outside the scope of the national tariff, as explained below.

### 2.1. Public health services

13. The national tariff does not apply to public health services:<sup>6</sup>
  - provided or commissioned by local authorities or Public Health England
  - commissioned by NHS England under its Section 7A public health functions agreement with the Secretary of State.<sup>7</sup>
14. 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

15. 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').<sup>8</sup>

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<sup>5</sup> [www.legislation.gov.uk/ukpga/2012/7/contents/enacted](http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted)

<sup>6</sup> 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).

<sup>7</sup> For the Section 7A agreement, see [www.gov.uk/government/collections/nhs-public-health-functions-agreements](http://www.gov.uk/government/collections/nhs-public-health-functions-agreements).

<sup>8</sup> 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.

16. 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**

17. 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.

18. 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.

19. 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 A (including national variations set out in Section 5) or subject to the local pricing rules (see Section 6.4).

20. 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.

21. 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.<sup>9</sup>

22. 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.
23. More information about implementing PHBs can be found on the [NHS Personal Health Budgets page](#).<sup>10</sup>

#### **2.4. Integrated health and social care**

24. 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.
25. 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.
26. Payment to providers of NHS services that are jointly commissioned are governed either by a national price as set out in Annex A (including national variations set out in Section 5) where applicable, or by a local price (including a local variation in Section 6.2).
27. 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**

28. Commissioners' application of CQUIN payments and contractual sanctions are based on provider performance, after a provider's income has been determined

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<sup>9</sup> See the National Health Service (Direct Payments) Regulations 2013 (SI 2013/1617, as amended) [www.legislation.gov.uk/uksi/2013/1617/contents/made](http://www.legislation.gov.uk/uksi/2013/1617/contents/made)

<sup>10</sup> [www.england.nhs.uk/healthbudgets/](http://www.england.nhs.uk/healthbudgets/)

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.

29. 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

30. 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.
31. 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**

Scenario	NTPS applies to provider	NTPS applies to commissioner	Examples
DA patient treated in England and paid for by commissioner in England	✓	✓	A Scottish patient attends A&E in England
DA patient treated in England and paid for by DA commissioner	✗	✗	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
English patient treated in DA and paid for by DA commissioner	✗	✗	An English patient, who is the responsibility of a CCG, attends A&E in Scotland

Scenario	NTPS applies to provider	NTPS applies to commissioner	Examples
English patient treated in DA and paid for by commissioner in England	✘	✔	An English patient has surgery in Scotland which is commissioned and paid for by their CCG in England

32. 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.
33. 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](#)<sup>11</sup> 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](#).<sup>12</sup>
34. 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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<sup>11</sup> [www.england.nhs.uk/publication/england-wales-crossborder-healthcare-services-statement-of-values-and-principles/](http://www.england.nhs.uk/publication/england-wales-crossborder-healthcare-services-statement-of-values-and-principles/)

<sup>12</sup> [www.england.nhs.uk/who-pays/](http://www.england.nhs.uk/who-pays/)

### 3. Currencies with national prices

35. 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.
36. 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.<sup>13</sup> The healthcare services to be specified must be agreed between NHS England and NHS Improvement.<sup>14</sup> 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.
37. 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.<sup>15</sup>
38. This section should be read with the following information set out in:<sup>16</sup>
- Annex A: 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 B: Guidance on currencies with national prices
  - Annex D: Guidance on best practice tariffs.

#### 3.1. Classification, grouping and currency

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

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<sup>13</sup> 2012 Act, Section 116(1)(a).

<sup>14</sup> 2012 Act, Section 118(7).

<sup>15</sup> Details available at <https://digital.nhs.uk/services/national-casemix-office/downloads-groupers-and-tools/grouper-and-tools-archive/costing-hrg4-2016-17-reference-costs-grouper>

<sup>16</sup> All available from: <https://improvement.nhs.uk/resources/national-tariff/>

- 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).
40. 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<sup>17</sup>
  - Office of Population Censuses and Surveys 5 (OPCS-5) for operations, procedures and interventions.
41. '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.<sup>18</sup> 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.<sup>19</sup>
42. 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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<sup>17</sup> The 5th edition update of ICD-10 was published in April 2015.

<sup>18</sup> <http://digital.nhs.uk/casemix/payment>

<sup>19</sup> 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](mailto: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.

43. We use spell-based<sup>20</sup> HRGs as the currency for most admitted patient care and some outpatient procedures, and as part of the payment approach for emergency care services (see Section 7).
44. 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.
45. 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**

46. 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.<sup>21</sup> Emergency care services are subject to the pricing rules specified in Section 7.
47. 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 D.
48. 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 A, B and D) includes the rules for determining which currencies and prices apply where a service is specified in more than one way.

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<sup>20</sup> A spell is a period from admission to discharge or death. A spell starts on admission of the patient.

<sup>21</sup> Prices for maternity services have been made non-mandatory to address an issue with the pricing of public health services. The [NHS operational planning and contracting guidance 2019/20](#) (section 3.2) states that providers and commissioners are expected to use these prices for contracting in 2019/20.

49. 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, which includes use of HRG4+ grouping for determining prices for those services, are set out in Section 7.

### **3.2.1. Admitted patient care**

50. 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.
51. 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.
52. 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.
53. 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.
54. 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.
55. When a patient has more than one distinct admission on the same day<sup>22</sup> (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.

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<sup>22</sup> Calendar day not 24-hour period.

56. Long stay payments<sup>23</sup> apply to admitted patient care. These are explained in detail below.
57. 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 and Annex A for details).

*Changes to the scope of services with national prices*

58. 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+.

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<sup>23</sup> 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.

59. 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*

60. 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<sup>24</sup> specific to the HRG and point of delivery.
61. 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 A.
62. For 2019/20, there is a trim point floor of five days.<sup>25</sup> There are two long-stay payment rates per chapter – one for child-specific HRGs and one for all other HRGs.
63. 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.
64. Long-stay payments may only be adjusted when **SUS+**<sup>26</sup> 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*

65. HRG subchapter SB covers both the procurement and the delivery of chemotherapy regimens for patients of all ages. The HRGs in this subchapter

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<sup>24</sup> 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.

<sup>25</sup> 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.

<sup>26</sup> <https://digital.nhs.uk/services/secondary-uses-service-sus>

are unbundled<sup>27</sup> and include activity undertaken in inpatient, day-case and non-admitted care settings.

66. 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.
67. The regimen list can be accessed from [NHS Digital](#).<sup>28</sup>

### *Radiotherapy*

68. 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.
69. 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.
70. 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.
71. 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.
72. The HRGs for radiotherapy treatment cover the following elements of care:
- external beam radiotherapy preparation – this has a national price

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<sup>27</sup> HRG4 introduced unbundled HRGs, making it possible to separately report, cost and remunerate the different components within a care pathway.

<sup>28</sup> <http://systems.digital.nhs.uk/data/clinicalcoding/codingstandards/opcs4/chemoregimens>

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

73. Further information on the structure of the chemotherapy and radiotherapy HRGs and payment arrangements can be found in Annex B.

### 3.2.3. Nuclear medicine

74. 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

75. 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.<sup>29</sup>

76. 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**<sup>30</sup>

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

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<sup>29</sup> More information on commissioning rehabilitation services can be found at: [www.england.nhs.uk/ahp/improving-rehabilitation](http://www.england.nhs.uk/ahp/improving-rehabilitation)

<sup>30</sup> Based on the care pathway outlined in the Department of Health and Social Care's 'Chronic Obstructive Pulmonary Disease (COPD) commissioning toolkit'.

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 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.

77. 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 A. 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.
78. 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.
79. The post-discharge national prices must be paid on completion of a full rehabilitation pathway.
80. 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.
81. Further information to support the implementation of all four post-discharge currencies, their scope and their specific rules can be found in Annex B.

### 3.2.5. Outpatient care

82. National prices for consultant-led outpatient attendances are based on clinic type, categorised according to treatment function code (TFC).<sup>31</sup> There are separate prices for first and follow-up attendances, for each TFC, as well as for single professional and multiprofessional clinics.<sup>32</sup>
83. 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 A.
84. 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%.
85. 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](#).<sup>33</sup>
86. 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.
87. When a patient has multiple distinct pre-booked outpatient attendances on the same day (eg 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.
88. 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

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<sup>31</sup> 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'.

<sup>32</sup> 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 B.

<sup>33</sup> [www.england.nhs.uk/nhs-standard-contract/](http://www.england.nhs.uk/nhs-standard-contract/)

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.

89. 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).
90. Commissioners and providers should use the NHS Data Model and Dictionary to decide the category of outpatient attendance and day-case activity.<sup>34</sup> 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.
91. 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.
92. 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.
93. 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.
94. 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

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<sup>34</sup> 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.

services. See the supporting document *Non-mandatory prices and currencies* for details.

#### *Non-face-to-face activity*

95. 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.
96. 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*

97. 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**

98. There are national prices for activity accessed directly from primary care, which are listed in Annex A. 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.
99. The outpatient Commissioning Data Set version 6.2 has a field that can be used to identify services that have been accessed directly.<sup>35</sup>
100. 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,

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<sup>35</sup> SUS R16 release (April 2016) has a requirement to add new functionality to implement the CDS6.2 new data item 'Direct access indicator'.

the core HRG should not attract any payment but the direct access service should attract a payment.

101. 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 A so that they can be used if a provider provides a report but does not carry out the scan.
102. There is also a non-mandatory price for direct access plain film X-rays.

### **3.2.7. Best practice tariffs**

103. 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.<sup>36</sup>
104. 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.
105. 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 A, B and D.
106. 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.

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<sup>36</sup> [High quality care for all](#), presented to Parliament in June 2008.

107. The service areas covered by BPTs are all:

- 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.

108. Details of all BPTs and their eligibility criteria are provided in Annex D.

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

- emergency laparotomy<sup>37</sup>
- spinal surgery.

110. 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).

111. 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).

112. 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

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<sup>37</sup> 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).

reimburse the costs of the activity unrelated to the BPT. For more information relating to the BPT flags see Annex A.

113. 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).
114. Full details of all BPTs and guidance on implementation and eligibility criteria are available in Annex D. 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**

115. Looked-after children<sup>38</sup> are one of the most vulnerable groups in society.
116. 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.
117. 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.
118. 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.

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<sup>38</sup> 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”.

119. 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 B.
120. National prices apply for children placed out-of-area (see the 'Other national prices' tab in Annex A). When a looked-after child is placed out-of-area' the responsible commissioner must commission providers in the receiving area to undertake the health assessments and pay them using the national price.
121. 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**

122. Pathway payments are single payments that cover a bundle of services<sup>39</sup> 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 (eg primary, secondary, community services and social care), has the potential to improve patient outcomes by reducing complications and readmissions.
123. 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, but this is non-mandatory and covered by local pricing rules. See Section 6.4 for details of the local pricing rules and the supporting documents *Non-mandatory prices* and *Guidance on the maternity pathway payment*.

#### *Cystic fibrosis pathway payment*

124. The cystic fibrosis (CF) pathway currency is a complexity-adjusted yearly banding system with seven bands of increasing complexity of patient need. The

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<sup>39</sup> Section 117 of the 2012 Act provides that a bundle of services may be specified as a single service (ie a currency) to which a national price applies, where those services together constitute a form of treatment.

tariff relates to a year of care. The pathway does not distinguish between adults and children.

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

- 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.

126. 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.

127. Further information is provided in Annex A.

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

128. 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 A. 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 A.

129. 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).

130. For the 2019/20 NTPS we have updated the list of drugs, devices and procedures.
131. 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.
132. We have also stated that consumables required uniquely for the deployment of listed devices should be subject to reimbursement outside national prices. Annex A gives the details and includes the full lists of drugs devices and procedures.

#### **3.4. The innovation and technology tariff**

133. 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.
134. 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).
135. 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.
136. 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

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

138. 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

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

140. 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.<sup>40</sup>

141. 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 further changes, including removing calculation steps that did not have any clearly identifiable policy

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<sup>40</sup> 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).<sup>41</sup> Where we have significantly deviated from the method used for the 2017/19 NTPS, we have set out the changes in this document.

142. 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*).
143. 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<sup>42</sup>
  - using the revised methodology for calculating market forces factor (MFF) values
  - incorporating revisions to the prescribed specialised services (PSS) eligibility lists, rules and hierarchy.
144. 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).
145. 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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<sup>41</sup> For details of these changes, see paragraphs 186-187 of the [2017/19 NTPS](#)

<sup>42</sup> This is done through a cash in/cash out process. Annex F 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 F.

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

147. 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**

148. 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.

149. 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.

150. 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.

151. 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 F).

152. 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).<sup>43</sup>
- 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 F). 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)
  - top-slicing admitted patient care prices (other than maternity, renal and unbundled) by £29.7 million and allocating the money to NHS England Specialised Commissioning to fund other cancer multidisciplinary team (MDT) services.
- 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 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).

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<sup>43</sup> 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.

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

153. 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
- 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.

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

155. 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.

156. All BPT prices are included in Annex A. Details of the compliance rates and implementation of BPTs are available in Annex D.

#### **4.2.3. Calculating outpatient attendance prices**

157. 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%.

158. Annex A contains a full list of outpatient frontloading levels.

## 4.3. Managing model inputs

### 4.3.1. Overall approach

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

- costs – 2016/17 reference costs<sup>44</sup>
- activity – 2016/17 HES and 2016/17 reference costs.

160. We explain these two datasets in more detail in this section.

161. 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.

162. 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).

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

164. 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.

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<sup>44</sup> See [2016/17 reference costs](#)

### *Reference cost dataset used*

165. We use 2016/17 reference cost data<sup>45</sup> for the prices for the 2019/20 NTPS. We use this reference cost dataset because it is closely aligned with the currency design<sup>46</sup> of the 2019/20 NTPS.

### *Reference cost data cleaning*

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

167. 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 fewer illogical relativities).<sup>47</sup> 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.

168. The data cleaning 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.

169. 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

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<sup>45</sup> See [2016/17 reference costs](#)

<sup>46</sup> We have used the HRG4+ currency system (see Section 3 for further details).

<sup>47</sup> 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).

produced by data errors. Small activity numbers increase the likelihood that prices can be distorted by such errors.

170. 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.

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

#### **4.3.2. HES data inputs**

172. 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.

173. 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.

174. 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**

175. 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.

176. 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.

177. 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: <sup>48</sup>
- 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.
178. 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 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.
179. We applied manual adjustments to exclude outlier costs for 12 HRGs where one provider's costs, in our view, distorted the price relativities.
180. 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.
181. 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.
182. 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.
183. These adjustments and those described above based on low activity levels and implausible costs were included in draft price relativities used for a second

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<sup>48</sup> Please note: these changes were made before the transfer of £1 billion into non-elective prices (see Section 4.2).

round of engagements with EWGs. They were also published in October 2018 as part of our engagement on [payment reform proposals](#).<sup>49</sup>

184. 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

185. 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 changed the amount recovered to 50% of the initial estimated loss. Table 4 displays the adjustment factors.

**Table 4: Subchapters and uplift adjustments**

Subchapter	Subchapter description	Uplift adjustment
HC	Spinal Procedures and Disorders	3.6%
HD	Musculoskeletal and Rheumatological Disorders	0.5%
HE	Orthopaedic Disorders	3.6%
HN	Orthopaedic Non-Trauma Procedures	3.6%
HT	Orthopaedic Trauma Procedures	3.7%
LD	Renal Dialysis for Chronic Kidney Disease	0.0%
PB	Neonatal Disorders	7.9%
SB	Chemotherapy	2.7%
SC	Radiotherapy	4.0%
	All remaining chapters	-0.6%

<sup>49</sup> <https://improvement.nhs.uk/resources/201920-payment-reform-proposals/>

#### 4.6. Cost base

186. 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.
187. 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.
188. 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.
189. 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.
190. 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).

191. 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.

192. 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. This amount is applied to all prices (both locally and nationally priced services) by making an adjustment in addition to the cost uplift factor in the tariff.<sup>50</sup>
- 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.<sup>51</sup>

#### 4.7. Cost uplifts and adjustments

193. The cost uplifts in the 2019/20 NTPS consist of three separate adjustments:

- inflation (including pay, drugs and capital costs and CNST contributions)
- cost base adjustment for CQUIN (see also Section 4.6)
- centralised procurement.

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<sup>50</sup> 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.

<sup>51</sup> 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.

194. As in the 2017/19 NTPS, there is no uplift for service development (see explanation below).

#### **4.7.1. Inflation**

195. 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.

196. We have retained broadly the same methodology for 2019/20 as for 2017/19 with some developments, as set out below.

197. In determining the inflation cost uplift adjustments, we considered six categories of cost pressures. These are:

- pay costs
- drugs costs
- other operating costs
- 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.

198. 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).

199. 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.

200. 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 5: Elements of inflation in the cost uplift factor**

<b>Cost</b>	<b>Estimate</b>	<b>Cost weight</b>	<b>Weighted estimate</b>
<b>Pay</b>	5.0%	66.9%	3.4%
<b>Drugs</b>	0.6%	3.7%	0.0%
<b>Capital</b>	1.8%	6.9%	0.1%
<b>CNST</b>	-1.0%	2.5%	-0.0%
<b>Other</b>	1.8%	20.0%	0.4%
<b>Total</b>		100.0%	3.8% <sup>52</sup>

**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%.

201. 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.

202. 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*

203. 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.

204. Pay-related inflation has three elements. These are:

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<sup>52</sup> Note: calculations are done unrounded – only one decimal place displayed

- 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.

205. 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.

206. 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.

207. 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.

208. In total, the projection is an increase in the pay bill of 5.0% in 2019/20.

209. 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*

210. 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.

211. 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.

212. 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 deflator<sup>53</sup> 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.

213. This results in assumed drugs cost inflation of 0.6% in 2019/20.

#### *Other operating costs*

214. 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,<sup>54</sup> is 1.8% in 2019/20.

215. 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*

216. 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.<sup>55</sup> NHS Resolution administers the scheme and sets the contribution that each provider must make to ensure the scheme is fully funded each year.

217. 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

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<sup>53</sup> The GDP deflator is a broad measure of general inflation. [www.gov.uk/government/statistics/gdp-deflators-at-market-prices-and-money-gdp-october-2018-budget-2018](http://www.gov.uk/government/statistics/gdp-deflators-at-market-prices-and-money-gdp-october-2018-budget-2018)

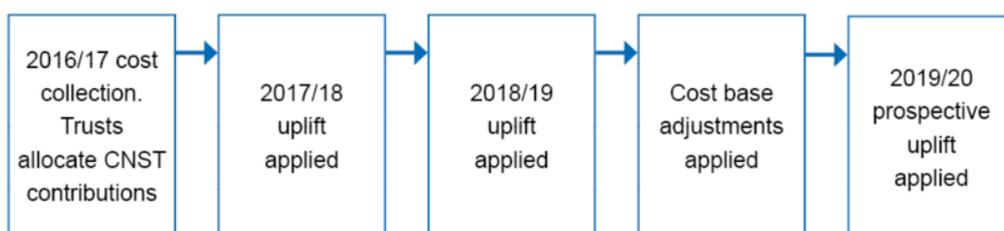
<sup>54</sup> Published at [www.gov.uk/government/statistics/gdp-deflators-at-market-prices-and-money-gdp-october-2018-budget-2018](http://www.gov.uk/government/statistics/gdp-deflators-at-market-prices-and-money-gdp-october-2018-budget-2018)

<sup>55</sup> CCGs and NHS England are also members of the CNST scheme.

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.<sup>56</sup> In 2019/20, CNST adjustments are not only applied to national prices – they are also applied to maternity and emergency care prices.

218. Figure 1 sets out our approach to including CNST in the national tariff.

**Figure 1: Including CNST in the national tariff**



219. 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 (including 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, the other cost uplifts and adjustments and the efficiency factor 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.

220. 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

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<sup>56</sup> 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.

that national prices in 2018/19 were set higher than they would have been if the actual contributions had been used.

221. 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.
222. Table 6 lists the percentage changes that we have applied to each HRG subchapter to reflect the change in CNST costs.
223. 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**

HRG sub chapter	2019/20 uplift (%)	HRG sub chapter	2019/20 uplift (%)	HRG sub chapter	2019/20 uplift (%)
AA	-0.47%	JA	-1.38%	PP	-1.46%
AB	-0.50%	JC	-0.67%	PQ	-0.57%
BZ	-0.70%	JD	-0.27%	PR	-1.23%
CA	-0.43%	KA	-0.62%	PV	-1.33%
CB	-0.29%	KB	0.05%	PW	-1.58%
CD	-0.18%	KC	-0.02%	PX	-1.31%
DZ	-0.04%	LA	-0.06%	SA	-0.25%
EB	-0.11%	LB	-0.44%	VA	-1.05%
EC	-0.14%	MA	-0.39%	WH	-0.43%
ED	-0.32%	MB	-0.56%	WJ	-0.08%
EY	-0.28%	PB	-1.19%	YA	-0.65%
FD	-0.56%	PC	-1.41%	YD	-0.14%

HRG sub chapter	2019/20 uplift (%)	HRG sub chapter	2019/20 uplift (%)	HRG sub chapter	2019/20 uplift (%)
FE	-0.36%	PD	-1.52%	YF	-0.87%
FF	-1.21%	PE	-0.58%	YG	-0.25%
GA	-0.98%	PF	-1.34%	YH	-1.22%
GB	-0.28%	PG	-1.01%	YJ	-1.31%
GC	-0.59%	PH	-1.10%	YL	-0.22%
HC	-1.00%	PJ	-1.44%	YQ	0.08%
HD	-0.52%	PK	-0.96%	YR	-0.10%
HE	-1.97%	PL	-0.96%		
HN	-1.25%	PM	-0.26%	VB	-1.09%
HT	-1.38%	PN	-0.77%	Maternity	-7.01%

Source: NHS Resolution. Note: Maternity is delivery element only

### *Capital costs (changes in depreciation and private finance initiative payments)*

224. 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.

225. 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<sup>57</sup> as a broad measure of inflation in the economy.

226. This results in assumed capital cost inflation of 1.8% in 2019/20.

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<sup>57</sup> Published at [www.gov.uk/government/statistics/gdp-deflators-at-market-prices-and-money-gdp-october-2018-budget-2018](http://www.gov.uk/government/statistics/gdp-deflators-at-market-prices-and-money-gdp-october-2018-budget-2018)

#### 4.7.2. Service development

227. The service development uplift factor reflects the expected extra unit costs to providers of major initiatives that are included in the Mandate.<sup>58</sup> 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

228. 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 an additional 1.25% increase in the cost uplift factor.

#### 4.7.4. Changes to product procurement arrangements

229. To address the recommendations on unwarranted variations, as described in [Lord Carter's review of NHS operational productivity](#),<sup>59</sup> DHSC has restructured the NHS Supply Chain operating model. This has involved the establishment of Supply Chain Coordination Limited (SCCL) under section 223 of the NHS Act 2006 to act as the in-house administration arm of the NHS Supply Chain. 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 and economies of scale. To help achieve this, SCCL's overhead costs (estimated to be around £253 million in 2019/20), will mostly be funded from central funds. This will enable the removal of "mark-ups" on product prices used in the provision of NHS services. Their removal will consequently reduce the direct cost to providers should they choose to procure supplies from the NHS Supply Chain.

230. To reflect the new funding arrangements for the new operating model for the NHS Supply Chain and the removal of the mark-up, 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).

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<sup>58</sup> The mandate to NHS England sets out objectives for the NHS and highlights the areas of healthcare where the government expects to see improvements.

<sup>59</sup> [www.gov.uk/government/publications/productivity-in-nhs-hospitals](http://www.gov.uk/government/publications/productivity-in-nhs-hospitals)

231. 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 NHS Supply Chain products. For nationally determined prices, the adjustment is 0.36%.

232. 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.

233. 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.

234. 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**

	Acute	Mental health	Ambulance	Community
<b>Adjustment to the cost uplift factor</b>	0.36%	0.10%	0.08%	0.05%

#### 4.8. Efficiency

235. The efficiency factor for 2019/20 is 1.1%.

236. 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.

237. 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.<sup>60</sup>
238. 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.
239. However, adjusting the time period of the model highlighted that the delivery of efficiencies has slowed in recent years.
240. 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**

241. Table 8 summarises the cost uplift and efficiency adjustments (both for national prices and local prices).
242. We have provided the changes by different service type to support local pricing in these areas. The only difference between service types is the adjustment relating to changes to product procurement arrangements.
243. The adjustments to national prices use the factors for acute services.
244. 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).

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<sup>60</sup> 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.

**Table 8: Summary of cost adjustments**

	Acute/ nationally priced services	Mental health	Ambulance	Community
<b>Cost uplift factor (before CQUIN and procurement adjustments)</b>	<b>3.8%</b>	<b>3.8%</b>	<b>3.8%</b>	<b>3.8%</b>
<b>CQUIN</b>	<b>1.25%</b>	<b>1.25%</b>	<b>1.25%</b>	<b>1.25%</b>
<b>Procurement changes</b>	<b>-0.36%</b>	<b>-0.10%</b>	<b>-0.08%</b>	<b>-0.05%</b>
<b>Efficiency factor</b>	<b>-1.1%</b>	<b>-1.1%</b>	<b>-1.1%</b>	<b>-1.1%</b>
<b>Total adjustments</b>	<b>3.6%</b>	<b>3.9%</b>	<b>3.9%</b>	<b>3.9%</b>
<p><b>Please note:</b> 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%.</p>				

## 5. National variations to national prices

245. 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.
246. 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’.
247. 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.
248. This section sets out the national variations specified in the 2019/20 NTPS.
249. 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 rule (MRET) and 30-day readmission rule, 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.

250. 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 disappplied 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).

251. 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**

252. 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.

253. 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 1.046155.**

The income that the trust receives from the commissioner for this outpatient attendance is £176 (£168 x 1.046155).

254. 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.
255. 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.
256. The MFF payment index values for 2019/20 (after application of the five-year transition) for each NHS provider are in Annex A.
257. 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.
258. 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.
259. 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*.

## 5.2. Variations to reflect patient complexity

### 5.2.1. Top-up payments

260. 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.
261. To set payments, we make an adjustment (a top-slice) to the total amount of money allocated to national prices and prices for maternity and emergency services and reallocate this money to providers of specialised services.
262. 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.<sup>61</sup>
263. 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.<sup>62</sup>
264. 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. 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+.

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<sup>61</sup> [Estimating the costs of specialised care](#) and [Estimating the costs of specialised care: updated analysis using data for 2009/10](#).

<sup>62</sup> <https://digital.nhs.uk/services/national-casemix-office/downloads-groupers-and-tools/prescribed-specialised-services-pss-tools>

**Table 9: Top-up impact by specialist area 2019/20**

Top-up area	Top-up amounts
All top-up areas	£485.9m
Spinal	£10.3m
Neurosciences	£117.1m
Orthopaedics	£3.1m
Children	£171.9m
Cancer	£19.7m
Respiratory	£72.2m
Cardiac	£74.5m
Other	£17.1m

265. 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.

266. A list of the services eligible for top-ups, the adjustments and their flags can be found in Annex A.

### 5.3. Variations to support new payment approaches

267. 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

268. 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.

269. 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.

270. 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*

271. 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*

272. 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.

273. 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.

274. 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*

275. 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**

276. 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.

277. 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.

278. NHS England has published details of the evidence-based interventions programme, including statutory guidance for CCGs.<sup>63</sup>

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<sup>63</sup> [www.england.nhs.uk/evidence-based-interventions/](http://www.england.nhs.uk/evidence-based-interventions/)

## 6. Locally determined prices

279. 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.

280. This section sets out the principles that apply to 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 G sets out guidance on the application of the principles, rules and method.<sup>64</sup>

281. 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 principles and rules in Sections 6.1 and 6.4.

282. This section is supported by the following annexes and supporting documents:<sup>65</sup>

- Annex A: National tariff workbook, which lists high cost drugs, devices and procedures
- Annex C: Currencies with no national price
- Annex E: Mental health clustering tool
- Annex G: Guidance on locally determined prices
- Guidance on blended payment for mental health services.

283. It is also supported by the following documents:<sup>66</sup>

- 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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<sup>64</sup> Commissioners have a duty to have regard to such guidance under the 2012 Act, Section 116(7).

<sup>65</sup> All available to download from: <https://improvement.nhs.uk/resources/national-tariff/>

<sup>66</sup> All available from: <https://improvement.nhs.uk/resources/locally-determined-prices/>

## 6.1. Principles applying to all local variations, local modifications and local prices

284. Subject to paragraph 286, 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.

285. 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,<sup>67</sup> and NHS Improvement's provider licence.

286. 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

287. 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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<sup>67</sup> 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

288. 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

289. 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.

290. 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)?<sup>68</sup>

- **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

291. Local variations are adjustments to a national price<sup>69</sup> 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.

292. 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 arrangement. 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.

293. 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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<sup>68</sup> 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.

<sup>69</sup> Local variations are covered by Sections 116(2), 116(3) and 118(4) of the 2012 Act.

294. When agreeing local variations, providers and commissioners 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

295. For a local variation to be compliant with the national tariff, commissioners and providers must comply with the following rules.<sup>70</sup>

#### 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.

296. Under the 2012 Act, commissioners must maintain and publish a written statement of any local variation.<sup>71</sup> 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.<sup>72</sup> Commissioners must therefore update the statement if they agree changes to the variations covered by the statement.

297. 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.<sup>73</sup> The completed template should be included in the commissioning contract (Schedule 3 of the [NHS Standard Contract](#)).

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<sup>70</sup> The rules in this section are made under the 2012 Act, Section 116(2).

<sup>71</sup> 2012 Act, Section 116(3).

<sup>72</sup> 2012 Act, Section 116(3)(b).

<sup>73</sup> Available from: <https://improvement.nhs.uk/resources/locally-determined-prices/>

298. NHS Improvement will publish the information submitted in the templates on its [Locally determined prices](#) web page so that all agreed local variations are accessible to the public from a single location. Where NHS Improvement publishes the information, 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?

299. 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.

300. 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.

301. 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.<sup>74</sup>
- 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.

302. 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.<sup>75</sup> To be approved or granted, NHS Improvement must be

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<sup>74</sup> Submission templates can be found at: <https://improvement.nhs.uk/resources/locally-determined-prices/>

<sup>75</sup> 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**

303. NHS Improvement's method<sup>76</sup> 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<sup>77</sup> must be supported by sufficient evidence to enable NHS Improvement to determine whether a local modification is appropriate, based on our method.

304. NHS Improvement's method requires that commissioners and providers:

- apply the principles outlined in Section 6.1
- demonstrate that services are uneconomic in accordance with Section 6.3.3
- comply with our conditions for local modification agreements and applications set out in Sections 6.3.4 to 6.3.6.

305. 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).

306. 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**

307. 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:

- The provider's average cost of providing each service is higher than the nationally determined price.

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<sup>76</sup> 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.

<sup>77</sup> 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.<sup>78</sup>

308. 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).

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<sup>78</sup> 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

309. 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).<sup>79</sup>

### 6.3.5. Additional conditions for local modification applications

310. 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 G (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)<sup>80</sup> 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<sup>81</sup> 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<sup>82</sup> 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).

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<sup>79</sup> 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)).

<sup>80</sup> See: *Guidance for commissioners on ensuring the continuity of health services; Designating commissioner requested services and location specific services*, 28 March 2013.

<sup>81</sup> Constructive engagement is also required by condition P5 of the provider licence, in cases where a provider believes that a local modification is required.

<sup>82</sup> Submission templates can be found at: <https://improvement.nhs.uk/resources/locally-determined-prices/>

311. 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*

312. 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.

313. 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*

314. The terms of a local modification agreement should be included in the relevant commissioning contract (using the NHS Standard Contract where appropriate)<sup>83</sup> 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.

315. 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)).

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<sup>83</sup> Providers and commissioners should refer to the latest available guidance on the NHS Standard Contract: [www.england.nhs.uk/nhs-standard-contract](http://www.england.nhs.uk/nhs-standard-contract).

## 6.4. Local prices

316. 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.<sup>84</sup> 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).

317. As well as the general rules, there are rules specific to particular services (see Sections 6.4.3 to 6.4.7).

318. In addition, Section 7 sets out the separate rules for emergency care services. The rules in this Section do not apply to those services.

319. Annex G provides additional guidance on the application of the local pricing rules.

320. Table 14 shows which rules apply to which area of activity.

**Table 14: Application of pricing rules**

Rule	Acute	Mental health	Community	Ambulance
1	✓	✓	✓	✓
2	✓	✓	✓	✓
3	✓	✓	✓	✓
4	✓	✓	✓	✓
5	✓	x	x	x
6	x	✓	x	x

<sup>84</sup> 2012 Act, Section 116(4)(b) and (12) and Section 118(5)(b).

Rule	Acute	Mental health	Community	Ambulance
7	x	✓	x	x
8	x	✓	x	x
9	x	✓	x	x
10	x	x	x	✓

#### 6.4.1. General rules for all services without a national price

321. 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

322. 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.

323. Details of these currencies are set out in Annex C, apart from PET/CT which has HRGs listed in Annex A.

324. 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 C.

325. The following rules apply when providers and commissioners are setting local prices for the services specified in paragraph 322.

### **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 C.

## 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.

326. The templates referred to in Rule 3 can be found [here](#).<sup>85</sup>

### 6.4.3. High cost drugs, devices and listed procedures

327. 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 A 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.

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<sup>85</sup> <https://improvement.nhs.uk/resources/locally-determined-prices/>

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 Service Condition 39 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

328. 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.

329. We are working to develop non-mandatory benchmark prices for IAPT services, which can be used as the starting point for discussions about setting local prices.

#### 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 E) 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 E) 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.<sup>86</sup> 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.

(c) 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 9: Patient choice**

Providers and commissioners must ensure that any agreed payment approach enables appropriate patient choice.

## **6.4.5. Ambulances services**

330. This section sets out the rules for local price-setting for ambulance services with and without national currencies.

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<sup>86</sup> Providers and commissioners can agree local variations from these rules if they meet the requirements of our rules on local variations.

331. In addition to rules 1 to 4, providers and commissioners must adhere to the requirements of rule 10.

### 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

332. 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.

333. 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*

334. 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*

335. 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).<sup>87</sup>

336. 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**

337. 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.

338. 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.

339. 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

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<sup>87</sup> These are arrangements made under the NHS Act 2006, Section 3 or 3A.

determine payment approaches that support high quality care for patients on a sustainable basis.

340. 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).
341. 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

343. 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.
344. Further detailed guidance is available in the supporting document *Guidance on blended payment for emergency care*.
345. 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.
346. 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).
347. The rules set out here do not apply to the blended payment for mental health (see Section 6.4.4 and the supporting document *Guidance on blended payment for mental health services*).

### 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 5(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<sup>88</sup>](#));
  - ii) emergency admission excess bed days;

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<sup>88</sup> Please see the NHS Data Dictionary for more details  
[www.datadictionary.nhs.uk/data\\_dictionary/attributes/a/add/admission\\_method\\_de.asp](http://www.datadictionary.nhs.uk/data_dictionary/attributes/a/add/admission_method_de.asp)

- 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;
  - 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;<sup>89</sup>
  - 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.

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<sup>89</sup> The Ambulatory Emergency Care Network defines ambulatory care as 'the provision of same day emergency care for patients being considered for emergency admission'.

- d) The 'unit price' for each individual service is:
- 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 A 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 A; 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 D, then the price payable in accordance with the paragraphs above is increased by the difference between the value of BPT 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 (b) and (c).
- 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)**

- a) 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.
- b) 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.
- c) Subject to paragraph (e), the price payable shall be:
  - i) the unit price for that service as defined in rule 2(d)(i) above or,
  - ii) if the relevant conditions are satisfied, the BPT price for that service.
- d) Subject to paragraph (e), if the service is not specified in Annex A, the price shall be agreed by the commissioner and provider in accordance with the local pricing rules in Section 6.4.
- e) In either case, the commissioner shall deduct from the total price payable to the provider for the provider's emergency care services activity for the financial year a sum equivalent to the agreed 2017/18 value of both the MRET and 30-day readmission rules for the provider, as confirmed by providers and commissioners as part of the Autumn 2018 data collection exercise.

## **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 5, 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

348. 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).<sup>90</sup>

### 8.1. Billing and payment

349. 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

350. For NHS activity where there is no national price, providers must adhere to any reporting requirements set out in the [NHS Standard Contract](#).

351. For services with national prices, providers must submit data as required under SUS guidance.<sup>91</sup>

352. The dates for reporting activity and making the reports available will be published on the NHS Digital website.<sup>92</sup> NHS Digital will automatically notify subscribers to its e-bulletin when these dates are announced.

353. 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<sup>93</sup> about these conditions and sets the actions that CCGs, CSUs and providers must take to ensure they act lawfully.

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<sup>90</sup> 2012 Act, Section 116(4)(c).

<sup>91</sup> <http://content.digital.nhs.uk/susguidance>

<sup>92</sup> <https://digital.nhs.uk/services/secondary-uses-service-sus/payment-by-results-guidance>

<sup>93</sup> See: *Who pays? Information governance advice for invoice validation* at [www.england.nhs.uk/wp-content/uploads/2013/12/who-pays-advice.pdf](http://www.england.nhs.uk/wp-content/uploads/2013/12/who-pays-advice.pdf)

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