NATIONAL TARIFF PROPOSALS 2017-19: ON THE DAY BRIEFING

NHS Improvement (NHSI) and NHS England (NHSE) have announced a series of policy and pricing proposals for the national tariff 2017-19 today, via a high level proposal document (commonly referred to as the tariff engagement document, TED), its accompanying preliminary impact assessment document, and a range of annexes and supporting information.

This briefing draws together a summary of all the key announcements, as well as our view on the new measures published today.

WHAT HAS BEEN PUBLISHED TODAY?

The main documents published today are the outline proposals for the tariff pricing and policy changes (TED) and the preliminary assessment of their impact, as well as annexes which provide more in-depth descriptions of the changes proposed:

- National tariff proposals for 2017/18 and 2018/19 (TED)
- Preliminary assessment
- Annex A: national tariff workbook
- Annex B: review and feedback document on draft price relativities
- Annex C: price setting models
- Annex D: rationale for adopting HRG4+ phase 3
- Annex E: developing the approach to setting the 2018/19 national tariff

The TED asks for engagement and feedback from the sector on the proposals. The deadline for feedback on the engagement is noon on 26th August 2016. Final price levels will be set over the coming months once NHSI has gathered feedback, which will then be subject to statutory consultation later in the year.

Other supporting documents have also been published:

- How mental health payment proposals support more efficient and effective care
- How mental health payment proposals support better care
- Best practice tariff proposals for 2017/18 and 2018/19
- Further areas for specific policy development
- Engagement grouper
- The metrics engine
Implementing a two year tariff

- NHSI propose to set the tariff for two years, from 2017/18 to 2018/19, with the intention being to support a two year planning round based on existing commissioner allocations. This will then be refreshed in 2019/20.
- To support this, NHSI will publish a statutory consultation later this calendar year on proposals for a national tariff which would last from April 2017 to March 2019. The aim is to have completed the statutory consultation before the end of the calendar year.
- This would include two price lists, one for each respective financial year. The latter will be different as it will reflect adjustments for inflation, efficiency, CNST and service development. NHSI are currently developing the full methodology for setting 2018/19 prices, but broadly propose to use the same principles as modelling 2017/18 prices in these areas. It should be noted that at this stage they are not engaging on these elements of the method that determine final price— this will be part of the statutory consultation.
- Currencies, national variations and business rules are planned to apply for both years.
- For 2017/18 and 2018/19 NHSI and NHSE propose to model prices from reference costs rather than roll over an existing price model, using 2014/15 reference costs and Hospital Episode Statistics (HES) data to set prices as part of a move to HRG4+ “phase 3 (see below for more details). There will be a range of manual adjustments to price relativities in line with previous years to mitigate where there is poor quality reference cost data (more detail in Annex B: review and feedback document on draft price relativities)
- The two year tariff will “limit, or remove”, the opportunity to make changes or introduce new policies in 2018/19. NHSI propose that no changes would be made to any aspect of the tariff (beyond those described above) until 2019/20 without consulting on, and introducing, a new national tariff.

National variations

For the two year 2017-19 national tariff the TED document proposes changes to one national variation: top-up payments for specialised services. This means NHSE and NHSI propose to retain the existing approach for the following national variations:
- Market forces factor
- 30 day readmission rule
- Marginal rate emergency rule
- Primary hip and knee

However, the proposals also note “We are considering the merits of introducing a marginal rate for specialised services for 2017 to 2019 and are doing further work on this ahead of the statutory consultation. We will seek advice from the specialised and complex care policy and technical advisory groups that we have established.”

Adoption of HRG4+ and related changes

NHSI propose to move to ‘phase three’ of the HRG4+ currency design for admitted patient care. This will be based on the latest available cost and activity data from 2014/15, and aims to better account for different levels of complexity and better reflect current clinical practice. NHSI propose to retain the same currency design for the second year of the proposed two year tariff.
• The proposals state HRG4+ phase three provides a more granular currency design that more accurately identifies and pays for the resources used to treat patients with different levels of complexity.
• Moving to HRG4+ means changing the structure of national prices, chapters and subchapters, the details of which are outlined more fully in Annex B: review and feedback document on draft price relativities.
• However the TED document also notes “We realise that some providers may have concerns about the price relativities published alongside this document, particularly providers of orthopaedic services. We are working with clinicians and representative groups to understand the underlying issues with prices in orthopaedics, which appear to be caused by the systematic underestimation of the costs of service provision in the way that costs are collected. In the short term, we are exploring how we might limit the impact of currency changes on revenue.”

To mitigate the impact of price changes in particular areas where this could destabilise services, they propose to limit price changes in some subchapters to 25% of the modelled change for that subchapter. The subchapters are:

- Orthopaedics;
- Renal dialysis;
- Neonatal disorders;
- Chemotherapy
- Radiotherapy

The move to HRG4+ will also mean a change to the scope of procedures included in national tariff prices. NHSI propose to introduce four new national prices for the 2017-19 national tariff:

- Cochlear implants
- Complex Computerised Tomography scans
- Complex therapeutic endoscopic, upper or lower gastrointestinal procedures
- Photodynamic therapy

Additionally NHSI proposes to remove the nationally mandated prices for outpatient follow-ups and set a new local pricing rule under which providers and commissioners would agree a single payment for all outpatient follow-ups.

Implementation of HRG4+ will also require some areas of tariff policy to change. These include:

1. Updating top-up payments for specialised services, with new top-ups for cancer, spinal and respiratory services, and developing a potential transition path to smooth the effect of these changes across services.
2. Introducing four new best practice tariffs (BPTs), amending four and removing two BPTs.
3. Updating the maternity pathway and updating the high cost drugs and devices lists.

**Top up payments for specialised services**

This year NHS Improvement and NHS England are considering making changes to specialised services top-ups, in light of changes to the way specialised services are defined. The changes would affect both 2017/18 and 2018/19. Previously, the services counting as ‘specialised’ were defined by the Specialist Services National Definition Set (SSNDS). NHS England has replaced this with a new Prescribed Specialist Services (PSS) list following the move to HRG4+. Following an econometric analysis, the University of York has made recommendations on which services on the PSS list should receive top-ups, and what the top-up rates should be.

NHSI and NHSE are proposing to implement these proposals which would increase specialist top-ups total spending from £323 million to £417 million. This increase is caused by the introduction of top-ups in several new areas.
(including cancer, respiratory and cardiac) totalling £100 million, as well as a £21 million increase in neurosciences, partly counterbalanced by a fall in spending on other existing top-ups areas. The table below outlines the top up revenue per specialist area under the scenario that has been selected.

<table>
<thead>
<tr>
<th>Top-up area</th>
<th>Top-up revenue (£m) under selected proposal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spinal</td>
<td>14</td>
</tr>
<tr>
<td>Neurosciences</td>
<td>88</td>
</tr>
<tr>
<td>Orthopaedics</td>
<td>4</td>
</tr>
<tr>
<td>Children</td>
<td>203</td>
</tr>
<tr>
<td>Cancer</td>
<td>14</td>
</tr>
<tr>
<td>Respiratory</td>
<td>27</td>
</tr>
<tr>
<td>Cardiac</td>
<td>59</td>
</tr>
<tr>
<td>Other</td>
<td>7</td>
</tr>
<tr>
<td><strong>All top-up areas</strong></td>
<td><strong>417</strong></td>
</tr>
</tbody>
</table>

The Preliminary assessment document outlines a further 4 scenarios outlining specialised service top-up options that NHSE and NHSI considered before selecting the above proposals as their preferred approach. Under scenario 5 (the central bodies’ preferred option), the change in top-up payments to teaching hospitals and to specialist hospitals would increase:

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<table>
<thead>
<tr>
<th>Provider type</th>
<th>S1 top-up revenue (£ million)</th>
<th>S2 top-up revenue (£ million)</th>
<th>S3 top-up revenue (£ million)</th>
<th>S4 top-up revenue (£ million)</th>
<th>S5 top-up revenue (£ million)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute - large</td>
<td>23</td>
<td>60</td>
<td>59</td>
<td>47</td>
<td>47</td>
</tr>
<tr>
<td>Acute - medium</td>
<td>1</td>
<td>16</td>
<td>15</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>Acute - small</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Acute - specialist</td>
<td>97</td>
<td>81</td>
<td>76</td>
<td>104</td>
<td>106</td>
</tr>
<tr>
<td>Acute - teaching</td>
<td>200</td>
<td>272</td>
<td>262</td>
<td>247</td>
<td>247</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>323</strong></td>
<td><strong>433</strong></td>
<td><strong>416</strong></td>
<td><strong>416</strong></td>
<td><strong>417</strong></td>
</tr>
</tbody>
</table>
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Source: NHS Improvement analysis (Note: Figures may not sum exactly due to rounding)

The new PSS top-ups (across scenarios 2, 3, 4 and 5) would all increase top-up payments for neurosciences. They would reduce top-up payments for orthopaedics, paediatrics and spinal (although to a lesser extent in scenarios 4 and 5, which attempt to mitigate these reductions). All of these scenarios also include four new areas eligible for top-ups: cancer, cardiac, respiratory and ‘other areas’ (mostly comprising GI surgery and urology).
### Best practice tariff changes

<table>
<thead>
<tr>
<th>New BPTs</th>
<th>Amended BPTs (changes)</th>
<th>Removed BPTs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Straight-to-test for patients requiring lower gastrointestinal investigation</td>
<td>Day case procedures (The BPT programme currently includes 15 procedures. NHSI have identified a further 19 procedures where the same approach could be taken)</td>
<td>Interventional radiology</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disorders (COPD)</td>
<td>Fragility hip fracture (NHSA propose to remove three measures: joint admissions protocol, multidisciplinary team working and post-op abbreviated mental test and replace them with: nutritional assessment during the admission, persistence with bone treatment after discharge, a delirium assessment during the admission and assessment by a physiotherapist the day following surgery)</td>
<td>Cataracts (non-mandatory)</td>
</tr>
<tr>
<td>Cardiac rehabilitation for myocardial infarction (MI)</td>
<td>Primary hip and knee replacements (stricter rules stricter rules to identify outliers on PROMs scale)</td>
<td></td>
</tr>
<tr>
<td>Non-ST segment elevation myocardial infarction (NSTEMI)</td>
<td>Same-day emergency care (propose to bring 13 additional HRGs into the in to the scope of the BPT)</td>
<td></td>
</tr>
</tbody>
</table>

NHSI and NHSE also propose to simplify and standardise the method for setting prices for BPTs by:

- 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.

This means in theory if providers do not achieve the BPT, then they will receive the lower price. If they achieve it then they will receive the higher price.

**NHSI have not carried out an impact assessment of the BPT proposals** “due to timing” as the proposed prices were only recently finalised. NHSI plan to include a comprehensive impact assessment of changes to all BPTs alongside the statutory consultation.

### Maternity and high cost drugs and devices

**Updates to Maternity Pathway:**

- The maternity pathway has three stages for payment: antenatal, delivery and postnatal. The antenatal and postnatal stages contain standard, intermediate and intensive levels, with higher prices for greater complexity.
- NHSI propose to update the casemix assumptions for the antenatal stage of the maternity pathway. The total amount of money allocated to the antenatal stage will not increase or decrease, however individual provider income will be determined by the maternity casemix. If the two year tariff is adopted, there would be no changes to the maternity pathway for 2018/19.
See Annex A: national tariff workbook for full list of changes.

Changes to high cost device list:
- The high cost devices list contains devices that are not subject to national prices but are negotiated locally in accordance with the rules on locally determined prices.
- NHSI propose to remove 10 out of the 28 categories of devices from the high cost list. NHSI propose to reimburse these costs through manual adjustments to the national tariff.
- See Annex A: national tariff workbook for full list of changes.

Mental health payment systems

NHSE and NHSI propose to make changes to the arrangements for locally determined prices in 2017/18 by requiring mental health commissioners and providers to agree local use of one of the following options:
- Episode of treatment or year of care, as appropriate to each mental healthcare cluster;
- Capitation, informed by care cluster data and other evidence; or
- An alternative payment approach consistent with the rules for local pricing and existing policy to move away from poorly specified and evidenced contracts.
- They also propose to mandate the use of the IAPT payment model from April 2018.
- These proposals do not include CAMHS or Secure & Forensic services, as currencies for these areas are under development and will be covered by separate arrangements. Providers and commissioners may choose to include these services within the scope of one of the payment approaches – consistent with the Local Payment Rules and principles.
- There would be no further changes to the rules for 2018/19.

NHS PROVIDERS VIEW

NHS Providers welcomes many of the proposals that are included in TED and the accompanying documents that have been published today. We have consistently called for a multi-annual tariff with appropriate opportunities for inter-year adjustment, believing that this will help create greater stability in the sector as finances become more constrained in the system in the coming years. Similarly, we broadly welcome the principles behind the move to HRG4+. Currencies that have greater granularity and are based on more up to date reference cost submissions should improve the accuracy of prices and help providers be more accurately reimbursed for the services they provide.

Although the consultation document notes that a two year tariff will entail limited opportunities to make changes or introduce new policies in 2018/19, there may well be additional national policy priorities (e.g. seven day services) that will impact on provider costs – the additional costs of these new priorities will have to incorporated into provider funding flows. We would want there to be some mechanism for the sector to feedback on any unforeseen substantial price changes in between years in the two year tariff process, to ensure any significant changes to costs or the impact of prices can be managed appropriately.

Similarly, with greater time now available for the tariff development process, we would also like to see engagement with the sector for the 2019/20 tariff follow a more in depth procedure that allows for a greater level of feedback and refinement of prices prior to publication.
However there are still several areas of concern however for us in the published proposals today. We note that the move to PSS and the impact on specialist top ups was proposed last year and its initial modelling seemed to indicate significant financial pressures for many individual providers. We await to see further details therefore as to how the balance of top up and transition payments will be spread across the different specialist areas over the four year period proposed. Similarly, while we welcome the recognition that orthopaedic price relativities remains an issue, it would be welcome if there was more detail provided on what mitigation NHSI have planned if there is limited scope for making substantial financial alterations to help address this area.

We would also reiterate our view that the marginal rate for emergency services should be removed, and would strongly advise against any potential introduction of a specialised marginal rate. National variations of this type do not incentivise providers to reduce demand, but rather damage their ability to plan effectively due to the negative impact they create on their revenue profile. The impact of cost and activity-containment measures for outpatients, and the introduction of additional day case BPTs will also need to be fully understood as these national changes may have a significant impact on provider financial positions.

We look forward to submitting a response to the proposals on behalf of our members.

ANNEX – PRELIMINARY IMPACT FINDINGS: NEW PRICE RELATIVITIES

- **Finding 1:** For 69% of NHS providers, the two most significant policy proposals affecting 2017/18 spending (changes to national prices and specialist top-ups), taken together, would change operating revenue by less than +/-1%. For 94% of NHS providers, the operating revenue change is less than +/-2%. Changes to operating revenue are most broadly distributed for specialist trusts; for 2 specialist trusts, operating revenue would fall by more than -3%, and for a further 3, operating revenue would increase by +2.9% or more. These impacts are largely driven by changes to national prices; national prices account for around 80 times as much provider revenue as specialist top-ups.

- **Finding 2:** NHSI estimate that taken together the proposed changes to national prices and specialist top-ups would decrease CCG spending by around £175 million, and increase NHS England spending by the same amount. This is mainly driven by changes to specialist top-ups (£97 million). They would not change the spending of any CCG by more than +/-1.3%.

- **Finding 3:** For 45 of 67 types of care, the proposed prices would change spending by <+/-5%. Measured in absolute terms, the biggest spending increases would be in maternity (+8.3%, £221 million), emergency medicine (+6.5%, £132 million) and nervous system procedures and disorders (+6.3%, £72 million). The biggest reductions would be in non-admitted consultations (-£223 million, -4.4%), interventional cardiology for acquired conditions (-£115 million, -12.1%),and Eyes and Periorbita Procedures and Disorders (-£71 million, -9.3%).

- **Finding 4:** For 73% of NHS providers who deliver nationally-priced services, the proposed national prices would change operating revenue by less than +/-1%. For 94% of NHS providers, the operating revenue change is less than +/-2%. The changes to operating revenue are most narrowly distributed for teaching and non-acute hospitals, and most broadly distributed for specialist hospitals. NHS Improvement and NHS England are considering whether and how to mitigate revenue volatility, particularly for the most-affected providers.

- **Finding 5:** The proposed national prices would reduce independent provider nationally-priced revenue by 2.5%, from £1.11 billion to £1.09 billion. This is largely driven by price reductions for orthopaedic non-trauma procedures (sub-chapter HN).

- **Finding 6:** For all CCGs, proposed national prices would change spending by less than +/-1.3% of their funding allocation. The national prices would increase NHS England spending by £35 million.
Finding 7: NHS Improvement and NHS England’s preferred scenario for specialist top-ups would increase specialist top-ups spending from £323 million to £417 million. This increase is caused by the introduction of top-ups in several new areas (including cancer, respiratory and cardiac) totalling £100 million, as well as a £21 million increase in neurosciences, partly counterbalanced by a fall in spending on other existing top-ups areas.