2020/21 National Tariff Payment System

November 2020

Contents

1. Introduction

1. This is the national tariff for the NHS in England. It specifies the following components that make up the National Tariff Payment System for 2020 to 2021 (the 2020/21 NTPS):

   - currencies
   - national prices
   - the method for determining those prices
   - the local pricing and payment rules, including the rules for blended payments
   - the methods for determining local modifications
   - related guidance.

2. Since 1 April 2016, Monitor and the NHS Trust Development Authority have operated as a single integrated organisation known as NHS Improvement. Since 1 April 2019, NHS England and NHS Improvement have come together to act as a single organisation. This document is published in exercise of functions conferred on Monitor by section 116 of the Health and Social Care Act 2012 (the 2012 Act). The proposals which form the basis of this national tariff were agreed between NHS England and Monitor under section 118 of the 2012 Act. In the rest of this document, 'NHS Improvement' means Monitor, unless the context otherwise requires.

3. This 2020/21 NTPS has effect for the period beginning on the date of publication and ending on 31 March 2021, or the day before the next national tariff published under section 116 of the 2012 Act has effect, whichever is the later.[1]

[1] If a replacement national tariff was to be introduced before the end of the one-year period, this tariff would cease to have effect when that new tariff takes effect.

The national tariff and Covid-19

In response to the Covid-19 pandemic, the NHS adopted special payment arrangements for 2020/21. Under these arrangements, most providers and commissioners moved to block contract payments 'on account'. Contracting and payment guidance to support this is available from the NHS England and NHS Improvement website.

However, the national tariff legislation and framework continues to apply. As the publication of the 2020/21 NTPS was delayed, the 19/20 NTPS has continued in effect for this financial year, up until the publication of this document. As the Covid-19 special payment arrangements involve departures from the national prices, currencies and blended payment arrangements specified in the NTPS, they involve local variations/departures agreed in accordance with the national tariff rules set out in Sections 6 and 7 of the 2019/20 NTPS. The contracting and payment guidance referred to above included a template statement to be used by commissioners to record those variations/departures and to submit for publication in accordance with section 116(3) of the Health and Social Care Act 2012. In addition, the NTPS continues to apply for services outside the scope of the emergency payment arrangements. This includes some activity delivered by independent sector providers. The NTPS prices also continue to be the basis on which charges for overseas visitors are calculated (see Section 2.7 below).

To note that the NTPS prices which applied from 1 April 2020 until the publication of this document are those set out in the 2019/20 NTPS. As part of the third phase of the NHS response to Covid-19, a revised financial framework applies during the latter part of 2020/21.[2] This framework will retain simplified arrangements for payment and contracting but with a greater focus on system partnership and the restoration of elective services.[3] The local variations and departures which underpin these arrangements will continue in effect under the rules in Sections 6 and 7 of this document.

2 www.england.nhs.uk/coronavirus/publication/third-phase-response/
3 www.england.nhs.uk/publication/elective-letter/

4. The document is split into the following sections:

- Section 2: the scope of the tariff
- Section 3: the currencies used to set national prices
- Section 4: the method for determining national prices
- Section 5: national variations to national prices
- Section 6: locally determined prices
- Section 7: rules for blended payments
- Section 8: payment rules.

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

Table 1: 2020/21 NTPS annexes

Annex	Description
A	National tariff workbook (including national prices and prices to be used for emergency care and outpatient attendance blended payments)
B	Guidance on currencies with national prices
C	Guidance on currencies with no national price
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 documents to the 2020/21 NTPS

Title
Non-mandatory prices workbook[4]
A guide to the market forces factor
Guidance on blended payments (including detailed guidance on emergency care, maternity, outpatient attendances and adult mental health services)

[4] This workbook contains non-mandatory prices, including those for maternity and outpatient attendances that can be used to construct the blended payments for these services (see Sections 7.2 and 7.3)

Guidance on maternity pathway payment
Understanding and using the national tariff

7. All annexes and supporting materials can be downloaded from the NHS England and NHS Improvement website.[5]

8. The national tariff forms part of a set of materials that inform planning and payment of healthcare services. Related materials include the NHS Operational Planning and Contracting Guidance, the NHS Standard Contract and guidance on Commissioning for Quality and Innovation (CQUIN). The guidance on 2020/21 financial arrangements in response to the Covid-19 pandemic should also be referred to.

9. For an introduction to the national tariff, please see the supporting document, Understanding and using the national tariff. If you have any questions about the tariff, please contact pricing@improvement.nhs.uk

5 https://improvement.nhs.uk/resources/national-tariff

2. Scope of the national tariff

10. As set out in the 2012 Act, the national tariff covers the pricing of healthcare services provided for the purposes of the NHS. Other than the exclusions described in Sections 2.1-2.7, 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.

11. Various healthcare services are, however, outside the scope of the national tariff. The rest of this section explains these exclusions.

2.1 Public health services

12. The national tariff does not apply to public health services that are:[6]

- 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[7]
- commissioned by NHS England or a CCG on behalf of a local authority pursuant to a partnership agreement under section 75 of the National Health Service Act 2006.

13. 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 prison.

6 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).

7 For the Section 7A agreement, see www.gov.uk/government/collections/nhs-public-health-functions-agreements.

2.2 Primary care services

14. The national tariff does not apply to primary care services (general practice, community pharmacy, general dental practice and community optometry) where payment for the services 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).[8]

15. 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 2020/21 NTPS rules on local price setting apply (see Section 6.4.6). For instance, local price-setting rules apply to minor surgical procedures performed by GPs and commissioned by CCGs.

2.3 Personal health budgets

16. A personal health budget (PHB) is a set 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.

17. There are three types of PHB:

- **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.

18. If an NHS commissioner uses a notional budget to pay providers of NHS services, this is in the scope of the 2020/21 NTPS. It will be either governed by national prices, as set out in Annex A (including national variations set out

[8] 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.

in Section 5), or subject to the local pricing rules (see Section 6.4, and Section 7 for services covered by blended payments).

19. A notional budget may also 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 2020/21 NTPS does not apply.

20. If a PHB takes the form of a direct payment to the patient or budget held by a third party, the payments for health and care services agreed in the care plan and funded from the PHB are not in the scope of the 2020/21 NTPS. Direct payments for healthcare are governed by regulations made under sections 12A(4) and 12B(1) to (4) of the 2006 Act.[9]

21. The following are not in the scope of the 2020/21 NTPS, as they do not involve paying for provision of NHS 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.

22. More information about PHBs can be found on the NHS Personal Health Budgets page.

2.4 Integrated health and social care

23. 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.

24. Where NHS healthcare services are commissioned under these arrangements ('joint commissioning'), they remain in the scope of the 2020/21 NTPS even if commissioned by a local authority.

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

25. 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 or any local variation under the rules in Section 6.2) where applicable, or by a local price (subject to the rules in Section 6.4 and Section 7).

26. Local authority social care or public health services commissioned under joint commissioning arrangements are outside the scope of the 2020/21 NTPS.

2.5 Contractual incentives and sanctions

27. Commissioners' application of CQUIN payments and contractual sanctions are based on provider performance, after a provider's income has been determined in accordance with the 2020/21 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 (see Section 8). However, as part of the Covid-19 response, in March 2020, contract sanctions were suspended until further notice and CQUIN payments were included within the block payment arrangements established for 2020/21.[10]

2.6 Devolved administrations

28. The pricing provisions of the 2012 Act cover healthcare services in the NHS in England only. The devolved administrations (DAs) are responsible for the NHS in Scotland, Wales and Northern Ireland. If a patient from Scotland, Wales or Northern Ireland is treated in England or vice versa, the 2020/21 NTPS applies in some but not all circumstances.

29. Table 3 overleaf summarises how the 2020/21 NTPS applies to various cross-border scenarios. 'DA commissioner' or 'DA provider' refers to a commissioner or provider in Scotland, Wales and Northern Ireland.

[10] For details, see Revised arrangements for NHS contracting and payment during the COVID-19 pandemic, published 26 March 2020

Table 3: How the 2020/21 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
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

30. In the final scenario above, the commissioner in England must follow the prices and rules in the 2020/21 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 6.4). 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 pricing.

31. Providers and commissioners should also be aware of guidance relating to cross-border payment responsibility. The England/Wales cross border healthcare services: statement of values and principles sets out the values and principles agreed between the NHS in Wales and the NHS in England to ensure smooth and efficient interaction between NHS organisations for patients along the England-Wales border. NHS England also provides comprehensive guidelines on payment responsibility in England.[11]

32. The payment responsibility rules set out in these documents should be applied as well as any applicable provisions of the 2020/21 NTPS. The scope of the 2020/21 NTPS does not cover these rules.

2.7 Overseas visitors

33. Overseas visitors who are liable to pay a charge under the relevant regulations are NHS patients where the cost of treatment is to be recovered from the individual. As such, where they receive treatment that falls within the scope of the national tariff, they should be charged based on commissioned prices. This might be national prices, including relevant national variations, or any applicable local variations or local prices. The charges will either be 100% or 150% of the commissioned price, depending on country of residence.

34. For more details, please see the overseas visitors charging rules.

[11] See the Who pays? guidance. For queries relating to commissioning responsibilities, you can also contact england.responsiblecommissioner@nhs.net

3. Currencies with national prices

35. A ‘currency’ is a unit of healthcare for which a payment is made. A currency can take many different forms; for example, it could involve a bundle of services for a group of patients or a particular population, or an individual episode of treatment.

36. 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 2020/21.

37. Under the 2012 Act, the national tariff must specify the NHS healthcare services for which a national price is payable.[12] The healthcare services to be specified must be agreed between NHS England and NHS Improvement.[13] The service specifications are referred to as currencies. 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.

38. 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 provisions for determining local prices which take the form of blended payments for emergency care, outpatient attendances and maternity services (see Section 7). The 2020/21 NTPS uses the version of the currency design that was used for the collection of the 2016/17 reference costs.[14]

39. This section describes the currencies with a national price. It should be read in conjunction with the following:[15]

12 2012 Act, section 116(1)(a).
13 2012 Act, section 118(7).
14 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
15 All available from: https://improvement.nhs.uk/resources/national-tariff/

- Annex A: National tariff workbook. This contains:

  lists of national prices (and related currencies)

  lists of high cost drugs, devices and procedures and innovative products whose costs are excluded from national prices (see Section 3.3 and 3.4) and instead subject to local pricing rules (see Section 6.4.3)

  a list of unit prices to be used to calculate blended payments for emergency care and outpatient attendances (see the blended payment rules in Sections 7.1 and 7.2).
- Annex B: Guidance on currencies with national prices.
- Annex D: Guidance on best practice tariffs.

3.1 Classification, grouping and currency

40. The national tariff relies on data. To operate effectively, the payment system needs:

    - **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 (healthcare resource groups – HRGs) 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).

41. Clinical classification systems describe information from patient records with standardised definitions and nomenclature. The 2020/21 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[16]

[16] The 5th edition update of ICD-10 was published in April 2015.

- OPCS Classification of Interventions and Procedures (OPCS-4) for operations, procedures and interventions.[17]

42. ‘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.[18] 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.[19]

43. The 2020/21 NTPS uses spell-based[20] HRGs as the currencies for most admitted patient care, and as part of the blended payments for emergency care, outpatient attendances and maternity services (see Section 7).

44. The HRG currency design used for the 2020/21 NTPS is HRG4+ phase 3. HRG4+ is arranged into chapters, each covering a group of similar conditions or treatments. Some chapters are divided into subchapters. The specific design for the 2020/21 NTPS is that used to collect 2016/17 reference costs. This is the same as was used for the 2019/20 NTPS, reflecting the rollover of price relativities (see Section 4.2).

45. The currencies for outpatient attendances are counted based on coding to identify clinical specialty and attendance type, defined by treatment function code (TFC). TFCs are used as part of the provisions for determining local prices for outpatient attendances (see Section 7.2). The supporting document *Guidance on blended payments* explains these currencies in more detail.

17 https://hscic.kahootz.com/connect.ti/t_c_home/view?objectId=14270896#14270896
18 http://digital.nhs.uk/casemix/payment
19 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
20 A spell is a period from admission to discharge or death. A spell starts on admission of the patient.

3.2 Currencies for which there are national prices

46. This section describes the currencies for which there are national prices. These currencies and national prices do not include emergency care, outpatient attendances and maternity services, which are subject to the pricing rules specified in Section 7 (or Section 6 in the case of maternity services commissioned by NHS England).

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 A.

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 with national prices, 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.

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.[21] Section 7 sets out the rules for the local pricing of emergency care, outpatient attendances and maternity services[22] as part of the blended payment arrangements.

Changes to the scope of services with national prices

50. The services for which there are national prices have changed from the 2019/20 NTPS in the following ways:

    - Outpatient attendances are no longer in the scope of national prices.
    - HRG WD02Z (Alzheimers Disease or Dementia, treated by a Non-Specialist Mental Health Service Provider) has been withdrawn. Having a national price for this HRG goes against our policy of not having national prices for the treatment of mental health patients by non-mental health service providers.

[21] Section 116(5) of the 2012 Act allows NHS Improvement to specify services (ie set currencies) for use in local pricing.
[22] Other than maternity services commissioned by NHS England.

- HRG LA97B (Same Day Dialysis Admission or Attendance, 18 years and under) has been withdrawn. This is because having a national price of zero has potential issues for paediatric haemodialysis payment.

3.2.1 Admitted patient care

51. Spell-based HRG4+ phase 3 is the currency design for admitted patient care (excluding emergency care and maternity services). A spell covers 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 a single spell had multiple FCEs.

52. When a patient has more than one distinct admission on the same day[23] (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.

53. 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.

54. The costs of some elements of the care pathway, such as critical care and high cost drugs, are excluded from national prices. Local prices should be agreed for these services using the local pricing rules in Section 6.4.

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

56. For a few HRGs there is a single price across outpatient procedures and day cases, or a single price across all settings. This is done where it is clinically appropriate to have a price that is independent of setting.

57. Long-stay payments[24] apply to admitted patient care. These are explained in detail below.

[23] Calendar day, not 24-hour period
[24] For patients who remain in hospital beyond an expected length of stay for clinical reasons, there is a reimbursement in addition to the national price called a ‘long-stay payment’

58. 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 blended payment approach for emergency care (see Section 7.1 and Annex A, tab 7 for details).

Long-stay payment

59. 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[25] specific to the HRG and point of delivery.

60. 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, tab 1.

61. For 2020/21, there is a trim point floor of five days.[26] There are two long-stay payment rates per chapter – one for child-specific HRGs and one for all other HRGs.

62. 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.

63. Long-stay payments may only be adjusted when SUS+ 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.

(sometimes referred to as an 'excess bed day payment'). The long-stay payment applies at a daily rate where the length of stay of the spell exceeds a 'trim point' specific to the HRG.

25 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.

26 For simplicity, there is a trim point floor of at least five days for all HRGs in Annex A, regardless of whether the HRG includes length of stay logic of less than five days.

3.2.2 Chemotherapy and radiotherapy

Chemotherapy

64. HRG subchapter SB covers both the procurement and the delivery of chemotherapy for patients of all ages. The HRGs in this subchapter are unbundled[27] and include activity undertaken in inpatient, day-case and non-admitted care settings.

65. Chemotherapy payment is split into two parts:

    - a core HRG (covering the primary diagnosis or procedure) – this has a national price
    - unbundled HRGs for chemotherapy delivery – these have national prices and, from 2020/21 include the cost of supportive drugs listed on the chemotherapy supportive drugs list.

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

Radiotherapy

67. HRG subchapter SC covers both the preparation and 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.

68. 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.

[27] To enable HRGs to represent activity and costs more accurately, some significant elements can be "unbundled" from the core HRGs that reflect the primary reason for a patient admission or treatment. These unbundled HRGs better describe the elements of care that comprise the patient pathway and can be commissioned, priced and paid for separately.

69. 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.

70. 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.

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

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

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

3.2.3 Nuclear medicine

73. Two 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 for outpatient procedures in the 2020/21 NTPS. This is the same as for other current empty core HRGs.

3.2.4 Post-discharge rehabilitation

74. 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 that clinical experts agree will facilitate better post-discharge rehabilitation and reablement for patients.[28]

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

- **Cardiac rehabilitation**
  The post-discharge price will only apply to the subset of patients identified

[28] More information on commissioning rehabilitation services can be found at: www.england.nhs.uk/ahp/improving-rehabilitation

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**[29]
  The post-discharge price will apply to patients discharged having had an acute episode of care for COPD. The national price can be paid only for patients discharged from acute care with an HRG for the spell of care of DZ65A to DZ65K, who subsequently complete a course of pulmonary rehabilitation.
- **Hip replacement rehabilitation**
  The national price can only be paid for patients discharged from acute care with an episode of care with a spell dominant procedure code (OPCS) 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 code (OPCS) of W401, W411, W421 or O181.

76. There are national prices in Annex A, tab 5, for these four post-discharge currencies for the care of patients where a single provider provides both acute and community services. Where services are not integrated, the national price does not apply. However, we encourage commissioners and providers to use these prices in local negotiations on post-discharge care pathways.

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

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

[29] Based on the care pathway outlined in the Department of Health and Social Care's 'Chronic Obstructive Pulmonary Disease (COPD) commissioning toolkit'.

79. 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.

80. Annex B contains further information on the implementation of all four post-discharge currencies, their scope and their specific rules.

3.2.5 Direct access

81. Annex A, tabs 4 and 5, includes national prices for activity accessed directly from primary care. 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.

82. The outpatient Commissioning Data Set version 6.2 has a field that can be used to identify services that have been accessed directly.[30]

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

84. In the case of direct access diagnostic imaging services for which there are national prices, the costs of reporting are included in prices. Annex A, tab 4, also shows these reporting costs separately so that they can be used if a provider provides a report but does not carry out the scan.

85. There is also a non-mandatory price for direct access plain film X-rays. See the *Non-mandatory prices* workbook.

3.2.6 Best practice tariffs

86. A best practice tariff (BPT) is usually a national price that is designed to incentivise quality and cost-effective care. In the 2020/21 NTPS, BPTs also form part of the arrangements for determining prices for emergency care and

[30] SUS R16 release (April 2016) has a requirement to add new functionality to implement the CDS6.2 new data item 'Direct access indicator'.

outpatient attendances, under rules for blended payments (see Sections 7.1 and 7.2).

87. The first BPTs were introduced in 2010/11 following Lord Darzi's 2008 review.[31] 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.

88. The aim of BPTs is to reduce unwarranted variation in clinical quality and spread best practice. BPTs may introduce an alternative currency, including a description of activities that are associated with good patient outcomes.

89. BPTs provide an incentive to move from usual care to best practice by creating a price differential between agreed best practice and usual care. See Section 4.2.2 for more detail on the method for setting BPT prices.

90. Where a BPT introduces an alternative currency for services with national prices, that currency should be used in the cases described below and as set out in Annexes A, B and D.

91. 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, many BPTs share similar objectives, such as:

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

92. 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

31 *High quality care for all*, presented to Parliament in June 2008.

these HRGs to reimburse the costs of the activity unrelated to the BPT. For more information relating to the BPT flags see Annex A, tab 6b.

93. The 2020/21 NTPS introduces a new adult asthma BPT. It also updates five existing BPTs:

- Acute stroke
- COPD
- Day-case procedures
- Fragility hip fracture
- Major trauma

94. Top-up payments for specialised services and long-stay payments apply to all 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 7.1).

95. Full details of all BPTs and guidance on implementation and eligibility criteria are available in Annex D. See also Section 7 and *Guidance on blended payments* for details of the operation of BPTs that are partly or wholly related to emergency care or outpatient attendances and therefore do not apply to national prices but to blended payment arrangements under local pricing rules.

3.2.7 Health assessments for looked-after children

96. Looked-after children[32] are one of the most vulnerable groups in society.

97. 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.

98. 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

[32] 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”.

placed out-of-area, the originating commissioner retains this responsibility. However, the health assessment should be done by a provider in the child's local area to promote optimal care co-ordination for the child.

99. 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.

100. To address this variability in the arrangements for children placed out-of-area and to enable more timely assessments, a national currency was devised. See Annex B for details of the currency and a checklist for implementing it.

101. National prices apply for children placed out-of-area (see Annex A, tab 5). 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.

102. 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. To support the development of local prices, non-mandatory prices are available for children placed in-area (see the *Non-mandatory prices* workbook).

3.2.8 Pathway payments

103. Pathway payments are single payments that cover a bundle of services[33] 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.

[33] 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.

104. For 2020/21, there is a nationally priced pathway-based payment system for patients with cystic fibrosis, described below.

105. A pathway-base system can also be used for maternity services, if providers and CCGs chose not to adopt the blended payment for maternity services set out in Section 7.3, or for those services outside the scope of blended payments. However, in either case this is non-mandatory and is covered by the applicable rules: rule 2(c) or 5 in Section 7.3 for services commissioned by CCGs, and the local pricing rules in Section 6.4 for services commissioned by NHS England. See also the supporting documents *Guidance on the maternity pathway payment* and the *Non-mandatory prices* workbook.

Cystic fibrosis pathway payment

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

107. 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.

108. The CF pathway currency was designed to support specialist CF 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.

109. See Annex A, tab 5, and Annex B for national prices and further information.

3.3 High cost exclusions

110. 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 (see in particular Section 6.4.3). The relevant drugs, devices and procedures can be found on the high cost lists in Annex A (tabs 13a and 13b). If they are not on these lists 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, tab 13b.

111. Where a drug, device or procedure is covered by a national price, but 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 variation rules (see Section 6.1 and 6.2).

112. For the 2020/21 NTPS we have updated the list of high cost drugs, devices and procedures, using the same guiding principles as in 2019/20.

113. In addition, from 2020/21, all cancer genetic tests are now reimbursed outside of national prices. The existing funding arrangements will continue for diagnostic tests which have been excluded from tariff since 2015. These tests are: NRAS/KRAS testing, BRAF testing, KIT testing, ALK testing (1), ALK testing (2), Oncotype DX, PD-L1, Prosigna and EnoPredict.

114. Annex A (tabs 13a and 13b) gives the details and includes the full lists of high cost drugs, devices and listed procedures.

3.4 The innovation and technology tariff/innovation and technology payment

115. For the 2019/20 NTPS, we removed reference to reimbursement arrangements for products covered by the ITT and ITP.[34] For 2020/21, the

[34] www.england.nhs.uk/aac/what-we-do/what-innovations-do-we-support/innovation-and-technology-payment/

reimbursement approach for selected innovative products is changing, with reimbursement on a local rather central basis.

116. To support this new approach, the national tariff includes a new list of innovative products, whose costs are excluded from national prices and are instead reimbursed through local prices – see tab 13c in Annex A.

117. Providers should be reimbursed for these items in addition to national prices.

118. These products will be reimbursed under the local pricing arrangements – provided for in the revised local pricing rule 5 (see Section 6.4.3). As part of the new arrangements, NHS England and NHS Improvement Innovation team may publish ‘reference prices’ to be used for some of these listed products (see Section 6.4.3).

4. Method for determining national prices

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

120. 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 it is more efficient and effective.

121. Providers and commissioners should continue to collaborate closely together to make the most effective and efficient use of resources to improve quality of care and health outcomes for the entire health care system.

4.1 Overall approach

122. We have set national prices for 2020/21.[35]

123. National prices for 2020/21 are modelled from the currency design set out in Section 3 of this document, with 2016/17 cost and activity data. The

[35] However, the applicable prices in the period from 1 April 2020 to the publication of this document are those set out in the 19/20 NTPS. References in this document to "national prices for 2020/21" are a reference to the prices set out in Annex A, which apply only from the date this 20/21 NTPS is published.

methodology for the tariff model for 2020/21 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 2019/20 NTPS.[36]

124. 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 intention (such as adjustments that appeared to be historic manual adjustments).[37]

125. The 2019/20 NTPS changed the methodology by:[38]

- including maternity services and emergency care in price calculations and related adjustments, despite these services not being covered by national prices
- introducing a cash in/cash out process that increased specificity in how total amounts of money are adjusted for changes in the scope of the tariff
- including a transfer of £1 billion from the Provider Sustainability Fund (PSF) into non-elective and A&E prices (despite them no longer being national prices)
- using the updated methodology for calculating market forces factor (MFF) values
- applying an updated manual adjustment process, including a standardised approach to treating prices based on very small numbers of cases.

126. The 2020/21 NTPS uses largely the same calculation method and currencies as 2019/20. However, rather than calculate new price relativities, the 2020/21 NTPS uses 2019/20 NTPS prices as initial relativities. In addition, outpatient attendances are included in price calculations and related adjustments despite these services no longer being covered by national prices (see Section 7.2).

36 For a description of the 2013/14 PbR method, please see Payment by results, step by step guide: calculating the 2013/14 national tariff.
37 For details of these changes, see paragraphs 186-187 of the 2017/19 NTPS
38 For details of these changes, see paragraphs 142-144 of the 2019/20 NTPS

127. We have again used the tariff calculation model built using the SAS software package that was used for the 2019/20 NTPS. The SAS code for the model is available in Annex F.

128. Section 4.2 explains the method for setting prices and the changes that have been made for 2020/21.

4.2 The method for setting prices

4.2.1 Modelling prices for 2020/21

129. Our modelling approach for 2020/21 involves the following steps:

- Take the 2019/20 NTPS prices and use them as price relativities for 2020/21.
- Adjust the prices relativities to an appropriate base year. As price relativities are based on 2016/17 reference costs, we need to adjust them to the current year (2019/20) before we can make any forward-looking adjustments. To do this we adjust the draft prices by applying the efficiency, inflation and Clinical Negligence Scheme for Trusts (CNST) adjustment factors for 2017/18, 2018/19 and 2019/20. 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 5.2).
- 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).[39]
- 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 sub-chapters and/or points of delivery), in line with agreed policy decisions or clinical advice. These adjustments are applied using the cash in/out approach introduced in 2019/20 (see Annex F). The amount allocated is draft prices multiplied by 2016/17 activity. The changes are based on the percentage difference between the initial amounts allocated and the desired amounts by point of delivery and/or subchapter,

[39] An example of an illogical relativity could be where the price for a more complex treatment is lower than the price for a less complex treatment without good reason.

with the prices changed by the same percentage. Examples of these changes include:

removing £77.8 million from the total amount reimbursed by the tariff to reflect cancer genetic testing being removed from the scope of the tariff (see Section 3.3)

transferring £29.1 million from NHS England Specialised Commissioning to increase chemotherapy delivery prices (SB11Z to SB15Z) to include chemotherapy supportive drugs (see Section 3.2.2)

transferring £12.9 million to NHS England Specialised Commissioning to fund complex knee revision surgery (see Section 5.2.1)

moving £15.7 million out of all prices, apart from renal dialysis, to increase postnatal maternity prices.

- Adjust prices to 2020/21 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 2020/21 (see Section 4.8).

130. This means we have set 2020/21 national prices using largely the same approach as the 2019/20 NTPS, other than rolling over the price relativities rather than calculating them from new cost and activity data.

4.2.2 Setting prices for best practice tariffs for 2020/21

131. For 2020/21, we have used the same method for setting BPTs that was used for 2019/20. 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.

132. As set out in Section 7, BPTs that relate to emergency care or outpatient attendances in part or in whole are included within blended payment

agreements. We have not changed the approach to calculating these BPT prices.

133. All BPT prices are included in Annex A, tab 6a. Details of the compliance rates and implementation of BPTs are available in Annex D.

4.3 Managing model inputs

4.3.1 Overall approach

134. The two main data inputs used to generate prices for the 2020/21 NTPS are:

- costs – 2016/17 reference costs[40]
- activity – 2016/17 Hospital Episode Statistics (HES)[41] and 2016/17 reference costs.

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

136. 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.

137. 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).

Reference cost dataset used

138. We use 2016/17 reference cost data for the prices for the 2020/21 NTPS. We use this reference cost dataset because it is closely aligned with the currency

40 See 2016/17 reference costs
41 See https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/hospital-episode-statistics

design[42] of the 2020/21 NTPS, reflecting the use of 2019/20 NTPS prices as price relativities.

Reference cost data cleaning

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

140. 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).[43] This, in turn, should reduce the number of modelled prices that require manual adjustment and should therefore increase the reliability of the tariff. We believe this benefit outweighs the disadvantage of losing some data points as a result of the data cleaning process.

141. 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.

142. 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

42 We have used the HRG4+ currency system (see Section 3 for further details).
43 An illogical relativity is where the cost of performing a more complex procedure is lower than the cost of performing a less complex procedure (without good reason).

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

143. 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.

144. For the prices in the 2020/21 NTPS, we only cleaned reference cost data for the APC module.

4.3.2 HES data inputs

145. In our modelling of the prices for the 2020/21 NTPS, we used 2016/17 HES data, grouped by NHS Improvement using the 2016/17 (HRG4+) payment grouper and the 2019/20 engagement grouper.

146. 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.

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

4.4 Manual adjustments

148. 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. For the 2019/20 NTPS we applied manual adjustments where price relativities were likely to be affected by very low activity numbers that could result in less robust reference cost data, and where illogical relativities were identified.[44]

149. For 2020/21 we asked for feedback on the 2019/20 NTPS prices as price relativities. We discussed the feedback with EWGs for the affected HRG chapter and made manual adjustments for the following HRGs:

[44] For full details of the manual adjustments for 2019/20, see Section 4.4 of the 2019/20 NTPS

- AA43* – Sleep Disorders. Some prices were inappropriately low due to an error in the day case and elective reference costs from a single centre performing a significant volume of total activity. We have therefore raised day case and elective prices to the average cost without the costing error. Non-elective prices have not changed.
- HT22* – Very Major Knee Procedures for Trauma. In the 2019/20 NTPS knee replacements for non-trauma in HN22 were priced higher than HT22, which includes knee replacements for trauma. We have uplifted the latter prices to correct this illogical relativity.

150. Where the manual adjustments increased the total amount allocated to a particular service, these were offset by reductions elsewhere in the HRG chapter or sub-chapter.

4.5 Volatility

151. 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. We continued this adjustment in 2019/20 but changed the amount recovered to 50% of the initial estimated loss.

152. For 2020/21, we have kept the amount recovered at 50%. 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%

Subchapter	Subchapter description	Uplift adjustment
SB	Chemotherapy	2.7%
SC	Radiotherapy	4.0%
	All remaining chapters	-0.6%

4.6 Cost base

153. 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.

154. For 2020/21, we have maintained our historic method for setting the tariff cost base. This equalises the cost base to that which was set in the previous tariff, adjusted for activity and scope changes.

155. As with many other parts of tariff setting, the previous year's tariff is a starting point for the following tariff. As such, we used 2019/20 prices and revenue as our starting point for calculating the cost base.

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

157. 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 national prices
- 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).

158. 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.

159. For 2020/21, it is our judgement that it is appropriate to keep the cost base equal to the revenue that would be received under 2019/20 prices, adjusted for activity and scope changes. This means that the cost adjustments made for 2019/20 (including transferring £1 billion from the Provider Sustainability Fund to A&E and non-elective prices and removing £204 million from the tariff to reflect changes to procurement arrangements) are reflected in the 2020/21 cost base.

4.7 Cost uplifts

4.7.1 Inflation

160. 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 factor.

161. We have used the 2019/20 methodology for 2020/21, with a minor adjustment to how costs are weighted in the final cost uplift factor (see paragraph 165).

162. In determining the inflation cost uplift, 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 2020/21.

163. 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.

164. 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 from published 2018/19 financial accounts. Table 5 shows the weights applied to each cost category.

165. For the cost weights, we used the 2019/20 NTPS cost uplift factor to adjust actual costs in the 2018/19 consolidated accounts. This reflects likely costs from 2019/20 in the cost weights used to set the cost uplift factor for 2020/21.

Table 5: Elements of inflation in the cost uplift factor

Cost	Estimate	Cost weight	Weighted estimate
Pay	2.9%	68.3%	2.0%
Drugs	0.6%	2.6%	0.0%
Capital	1.8%	7.2%	0.1%
CNST	3.2%	2.3%	0.1%
Other	1.8%	19.6%	0.4%
Total		100.0%	2.5%[45]

166. 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 costs relating to placements funded directly by Health Education England (trainee salaries are included within pay costs).

[45] Note: calculations are done unrounded – only one decimal place displayed

- High-cost drugs, which are not reimbursed through national prices (see Section 3.3).

167. Below, we describe our method for estimating the level of each inflation-related cost uplift component and the CNST adjustments.

Pay

168. As shown in Table 5, pay costs are a major component of providers' aggregate input costs. Therefore it is important that we reflect changes in these costs as accurately as possible when setting national prices.

169. Pay-related inflation has three elements:

- 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 2020/21. The additional employer pension costs, arising from the change in the employer contribution rate from 1 April 2019, are not included in the cost uplift.[46]

170. We use estimates or assumptions for these components. These are calculated based on the best available information on pay inflation, which uses the latest labour cost data and estimates growth in line with agreed pay awards. We assume pay drift effects of 0.1% in 2020/21.

171. New pay settlements were introduced for both Agenda for Change (AfC) and medical staff in 2018/19 and these will increase pay further in 2020/21. Some additional medical pay costs for 2019/20 were funded directly with providers and these will be brought into the 2020/21 NTPS through the cost uplift:

- AfC pay settlements are estimated to increase by 2.9% in 2020/21.

[46] Approach to funding these costs operated in 2019/10 will continue in 2020/21. See NHS Operational Planning and Contracting Guidance 2020/21, page 31. www.england.nhs.uk/publication/nhs-operational-planning-and-contracting-guidance-2020-21/

- Medical pay costs (career/staff grades and core consultant) are estimated to increase by 0.5% in 2019/20 (above the increase already included in the NTPS) and by 2.1% in 2020/21.
- Medical pay costs (trainee grades) are estimated to increase by 0.3% in 2019/20 (above the increase already included in the NTPS) and by 3.2% in 2020/21.

172. The combined estimated impact of pay settlements and drift to be included in the cost uplift for 2020/21 is therefore 2.9% for AfC and 2.8% for non-AfC. These figures are weighted by the proportions of each to total pay costs.

173. A breakdown of the pay inflation estimate is shown in table 6.

Table 6: Breakdown of pay inflation estimate

	2020/21 inflation (including pay drift)	2019/20 catch-up	Total inflation	Weight (as a % of all pay costs)	Weighted inflation
Agenda for Change	2.9%	0.0%	2.9%	75%	2.2%
Medical (career/staff grades)	2.1%	0.5%	2.6%	3%	0.1%
Medical (trainee grades)	3.2%	0.3%	3.5%	7%	0.3%
Consultants (core)	2.1%	0.5%	2.6%	14%	0.4%
Consultants (local CEAs)	2.1%	- 2.0%	0.1%	1%	0.0%
Total:					**2.9%**

174. In total, the projection is an increase in the pay bill of 2.9% in 2020/21.

175. 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

176. The drugs cost uplift is intended to reflect increases in drugs expenditure per unit of activity.

177. We used the GDP deflator estimated by the Office for Budget Responsibility (OBR)[47] 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. The GDP deflator, from September 2019,[48] was 1.8% for 2020/21. Publishing the 2020/21 NTPS later in 2020 than expected means that more recent deflators have been published. However, we feel that it is appropriate to continue to use the September 2019 value, particularly as that was used in the prices originally consulted on and so maintains certainty and consistency with the proposals on which we sought the views of the stakeholders.

178. This results in assumed drugs cost inflation of 0.6% in 2020/21.

Other operating costs

179. Other operating costs include general costs such as medical, surgical and laboratory equipment and fuel.

180. We again used the OBR GDP deflator as the basis of the expected increase in costs (1.8%). As with drugs costs, we feel it is appropriate to continue to use the September 2019 deflator, despite the late publication of the 2020/21 NTPS. This ensures NTPS prices are consistent with those consulted on.

Clinical Negligence Scheme for Trusts

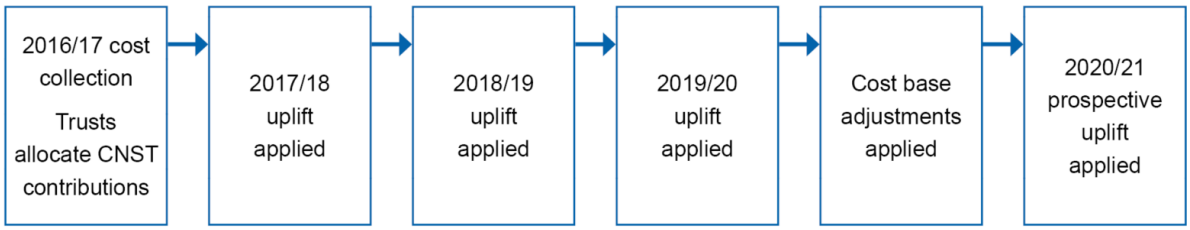
181. The CNST is an indemnity scheme for clinical negligence claims. Providers contribute to the scheme to cover the legal and compensatory costs of clinical negligence.[49] NHS Resolution administers the scheme and sets the contribution that each provider must make to ensure the scheme is fully funded each year.

47 The GDP deflator is a broad measure of general inflation.
48 Published at www.gov.uk/government/statistics/gdp-deflators-at-market-prices-and-money-gdp-september-2019-quarterly-national-accounts
49 CCGs and NHS England are also members of the CNST scheme.

182. We have allocated the change in CNST costs to core HRG subchapters, to the maternity delivery tariff and A&E services, in line with the average cost increases that will be paid by providers. This approach is different to other cost adjustments, which are estimated and applied across all prices. Each relevant HRG is adjusted based on the change in CNST cost across specialties mapped to HRG subchapters. This means that our cost adjustments reflect, on average, each provider's relative exposure to CNST cost changes, given their individual mix of services and procedures.[50] In 2020/21, CNST adjustments are not only applied to national prices – they are also applied to maternity and emergency care prices.

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

Figure 1: Including CNST in the national tariff



184. A provider's CNST contributions are included in its reference costs. For the 2020/21 NTPS, these are 2016/17 reference costs. The cost uplift (including CNST) and efficiency factors for 2017/18, 2018/19 and 2019/20 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 2019/20 NTPS prices and the total amount of CNST included in 2020/21 prices (national prices and prices for emergency care and maternity services).

[50] 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.

185. Table 7 lists the percentage changes that we have applied to each HRG subchapter to reflect the change in CNST costs.

186. Most of the changes in CNST costs are allocated at HRG subchapter level, maternity or A&E, but a small residual amount (about £61.9 million in 2020/21) 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 0.1% in 2020/21.

Table 7: CNST tariff impact by HRG subchapter

HRG sub chapter	2020/21 uplift (%)	HRG sub chapter	2020/21 uplift (%)	HRG sub chapter	2020/21 uplift (%)
AA	0.51%	JA	0.00%	PP	1.05%
AB	-0.06%	JC	0.49%	PQ	0.44%
BZ	0.46%	JD	0.38%	PR	0.79%
CA	0.50%	KA	0.27%	PV	0.23%
CB	0.54%	KB	0.60%	PW	0.95%
CD	0.91%	KC	0.54%	PX	0.82%
DZ	0.48%	LA	0.49%	SA	0.82%
EB	0.55%	LB	0.24%	VA	-0.27%
EC	0.13%	MA	-0.19%	WH	0.48%
ED	0.14%	MB	0.05%	WJ	0.30%
EY	0.19%	PB	1.03%	YA	0.83%
FD	0.31%	PC	0.90%	YD	0.40%
FE	0.23%	PD	0.97%	YF	0.10%
FF	-0.07%	PE	0.55%	YG	0.17%
GA	-0.09%	PF	0.81%	YH	-0.32%
GB	0.15%	PG	0.53%	YJ	-0.10%
GC	0.31%	PH	0.49%	YL	0.15%

HRG sub chapter	2020/21 uplift (%)	HRG sub chapter	2020/21 uplift (%)	HRG sub chapter	2020/21 uplift (%)
HC	0.71%	PJ	1.01%	YQ	0.09%
HD	0.10%	PK	0.65%	YR	0.22%
HE	-0.89%	PL	0.53%		
HN	-0.98%	PM	0.25%	VB	-0.62%
HT	-0.98%	PN	0.49%	Maternity	9.22%

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

187. 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.

188. As in 2019/20, our methodology to calculate the cost uplift uses the OBR GDP deflator.[51] This results in assumed capital cost inflation of 1.8% in 2020/21.

4.7.2 Service development

189. The service development uplift factor reflects the expected extra unit costs to providers of major initiatives that are included in the Mandate.[52] There are no major initiatives anticipated in the Mandate to be funded through national prices in 2020/21, and no uplift is to be applied.

4.8 Efficiency

190. The efficiency factor for 2020/21 is 1.1%.

51 Published at www.gov.uk/government/statistics/gdp-deflators-at-market-prices-and-money-gdp-september-2019-quarterly-national-accounts
As with drugs costs, we feel it is appropriate to continue to use the September 2019 deflator, despite the late publication of the 2020/21 NTPS. This ensures the 2020/21 NTPS prices are consistent with those consulted on.

52 The Mandate to NHS England sets out objectives for the NHS and highlights the areas of healthcare where the government expects to see improvements.

191. 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. Residual differences between trusts are used to estimate the distribution of efficiency across the sector.

192. The model now includes data from 168 acute trusts for the period between 2008/09 and 2017/18.

193. Our modelling suggests that trusts have become 0.9% more efficient each year on average. Around this trend, we estimate that there is substantial variation in efficiency that could justify an efficiency factor greater than 0.9% (ie if poorer performers, with greater efficiency opportunities, improved their efficiency at a greater rate). For instance, if the average performer catches up to the 60th centile we estimate that this would release 1.4% efficiency in addition to trend efficiency.

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

195. We have set an efficiency factor of 1.1% for 2020/21. We regard this as challenging but achievable given the evidence around catch-up potential and trends in efficiency and financial pressure.

5. National variations to national prices

196. 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.

197. 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’.

198. Specifically, each national variation aims to either:

- 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.

199. This section sets out the national variations specified in the 2020/21 NTPS.

200. National variations are an important part of the payment system framework. They sit alongside local variations and local modifications. Providers and commissioners should note:

- national variations only apply to services with a national price
- if a commissioner and a provider choose to bundle services that have a mix of national prices and locally determined prices, national variations can in effect be disapplied or modified by local variations agreed in accordance with the applicable rules (see Section 6.2)
- in the case of an application or agreement for a local modification (see Section 6.3), the analysis must reflect all national variations that could alter

the price payable for a service (ie it is the price after any national variations have been applied that should be compared with a provider's costs)

- where a new service is commissioned that does not have a national price, rules for local price setting apply (see Section 6.4).

201. 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

202. The purpose of the market forces factor (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.

203. 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 vasectomy procedure, which has a national price of £565.

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 £591 (£565 x 1.046155).

204. Further information on the calculation and application of the MFF is provided in the supporting document, *A guide to the market forces factor*.

205. In 2019/20 we revised the calculation method and data used for the MFF, assigning new MFF values to all organisations. The new values are being phased in over a five-year period in equal steps.

206. For 2020/21, MFF values for each NHS provider represent the second step of this transition. All MFF values for 2020/21 are available in Annex A, tab 12.[53]

207. Moving to the second step of the transition further reduces the total amount of money paid through the MFF, with compensating increases in national prices and prices for emergency care, outpatient attendances and maternity services. The resulting increase in 2020/21 prices, compared to using 2019/20 MFF values, is 0.38%.

208. 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.

209. 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 than provider A, 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 than provider A, discussion with the commissioner is needed to ensure the provider is adequately compensated for the delivery of the service.

210. Organisations merging or undergoing other organisational restructuring after the publication of the 2020/21 NTPS will not have a new MFF set during the

[53] However, these values only apply to prices from the date of publication of this 2020/21 NTPS. The applicable MFF values from 1 April 2020 to publication are those set out in the 2019/20 NTPS.

period covered by this tariff. For further guidance in these circumstances see the supporting document, *A guide to the market forces factor*.

211. Providers should notify NHS Improvement of any planned changes that might affect their MFF value. Email pricing@improvement.nhs.uk

5.2 Variations to reflect patient complexity

5.2.1 Top-up payments

212. 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 specialised care.

213. To set payments, we make an adjustment (a top-slice) to remove money from the total amount allocated to national prices and prices for emergency care, outpatient attendances and maternity services. We then reallocate this money to providers of specialised services.

214. 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.[54]

215. 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.[55]

54 Estimating the costs of specialised care and Estimating the costs of specialised care: updated analysis using data for 2009/10.

55 https://digital.nhs.uk/services/national-casemix-office/downloads-groupers-and-tools/prescribed-specialised-services-pss-tools

216. Top-up payments are only made for inpatient care. Table 8 shows the breakdown of the amount it was calculated would be received by different specialist 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+. However, the payment arrangements for 2020/21 and the impact of Covid-19 on activity make it impossible to specify the top-up amounts that would be received in practice.

Table 8: Top-up impact by specialist area 2020/21

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

217. We have changed the top-ups payable for 2020/21 based on the most up-to-date PSS flags and recent activity data (2018/19 HES).

218. A list of the services eligible for top-ups, the adjustments and their flags can be found in Annex A, tab 14.

Payment approach for complex knee revision surgery

219. For 2020/21, we have introduced a new payment approach for knee revision surgery. This aims to support orthopaedic providers to deal with complex activity. The approach involves the following:

- Transferring £12.9 million to NHS England Specialised Commissioning from the total amount allocated by the tariff to orthopaedic and trauma services. Specialised Commissioning will then fund, in addition to the national tariff prices and top-ups, providers of knee revision surgery for complex activity. Providers will receive a core payment, based on historical activity levels

and national prices. They will then receive additional payments for complex activity, funded by the transferred amount.

- A ‘hub and spoke’ network of specialist providers is being established, leading local systems to support the delivery of best practice clinical standards defined by GIRFT.
- A multidisciplinary (MDT) referral service, led by GIRFT, will determine which cases are managed by the specialist centres’ regional hubs and which are undertaken by local hospitals (the spokes).

220. We will assess the impact of the approach for knee revision surgery in 2020/21. If successful, we may look to broaden the approach to cover a wider range of services in future years.

5.3 Variations to support new payment approaches

221. 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

222. In some circumstances, providers are unable to demonstrate that they meet all the criteria for the primary hip and knee replacement BPT, but it would be inappropriate for them not to receive the full BPT price. These 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.

223. Under this national variation, commissioners must pay the full BPT if a provider can show that any of these circumstances apply. The rationale for using a variation in these three circumstances is explained below.

Recent improvements

224. 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

225. 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.

226. In this situation, the variation would be a time-limited agreement. Published data would need to show improvements for BPT-level payment to continue.

227. There are many factors that may affect patient outcomes, and it is for local providers and commissioners to decide how to achieve improvements. However, 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.[56] This is a quality improvement process that seeks to improve patient care and outcomes through a systemic review of care against expected criteria.

Casemix

228. Providers that have a particularly complex casemix and cannot show they meet the best practice criteria may request that the commissioner pays 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

229. 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.

230. 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 an individual funding request (IFR) is made and approved:

- 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.

[56] For information about clinical audits, see: www.england.nhs.uk/clinaudit/

231. NHS England has published details of the evidence-based interventions programme, including statutory guidance for CCGs.[57]

232. For 2020/21, two additional procedures may be added to the national variation (subject to consultation). These procedures are:

- exercise ECG for screening for coronary heart disease
- helmet therapy in the treatment of positional plagiocephaly in children.

233. In each case the national variation applies in relation to the procedure only where, following consultation, NHS England and NHS Improvement have issued a determination that the procedures should be included in the evidence-based interventions list. Unless and until such determination is published, the national price for these procedures is payable regardless of whether an IFR has been made or approved.

57 www.england.nhs.uk/evidence-based-interventions/

6. Locally determined prices

234. 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.

235. This section sets out:

- the principles that apply to locally determined prices (Section 6.1)
- the rules for local variations (Section 6.2)
- the method used by NHS Improvement to assess local modifications (Sections 6.3)
- rules on local prices (Section 6.4).

236. Annex G sets out guidance on the application of the principles, rules and method. Commissioners have a duty to have regard to such guidance under the 2012 Act, section 116(7).[58]

237. Emergency care, outpatient attendances and maternity services are not subject to national prices. The local prices for those services are, however, to be determined in accordance with the detailed rules in Section 7 or, in the case of maternity services commissioned by NHS England, the local pricing rules in Section 6.4.

238. This section is supported by the following annexes and supporting documents:[59]

- Annex A: National tariff workbook, which lists high cost drugs, devices and procedures and certain innovative products

[58] 'To have regard' requires commissioners to consider the guidance and take it into account when applying the rules and procedures relating to local variations, local prices or local modifications. Commissioners are not bound to follow the guidance, but must have good reasons for departing from it.

[59] All available to download from: https://improvement.nhs.uk/resources/national-tariff/

- Annex C: Currencies without national prices
- Annex E: Mental health clustering tool
- Annex G: Guidance on locally determined prices
- Guidance on blended payments.

239. It is also supported by the following documents:[60]

- local variations and local prices template (relevant to Sections 6.2 and 6.4)
- local modifications template (relevant to Section 6.3).

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

240. Subject to paragraph 242, 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.

241. These principles are explained in more detail in Sections 6.1.1 to 6.1.3 and are additional to other legal obligations on commissioners and providers. These obligations include other rules set out in the national tariff, and the requirements of competition law, procurement law, regulations under section 75 of the 2012 Act,[61] and NHS Improvement's provider licence.

242. The pricing of emergency care, outpatient attendances and maternity services (other than maternity services commissioned by NHS England) is subject to the detailed rules in Section 7 and the local pricing principles do not apply to these services.

60 All available from: https://improvement.nhs.uk/resources/locally-determined-prices/
61 See the National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2013 (SI 2013/500).

6.1.1 Best interest of patients

243. 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?
- **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

244. 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

245. Providers and commissioners must engage constructively with each other to decide on the mix of services, delivery model and payment approach that

delivers 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. Constructive engagement is intended to support better and more informed decision making in both the short and long term.

246. 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)?[62]
- **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

247. Local variations are adjustments to a national price or a currency for a nationally priced service (or both), agreed by one or more commissioners and one or more providers.[63] 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.

62 The NHS Standard Contract is used by commissioners of healthcare services (other than those commissioned under primary care contracts) and is adaptable for use for a broad range of services and delivery models.

63 Local variations are covered by sections 116(2) and (3) and 118(4) of the 2012 Act.

248. 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:

- 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.

249. However, this is not an exhaustive list and it is for commissioners and providers to determine the approaches that would be most appropriate locally.

250. 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. In addition, it is not appropriate for local variations to be used to introduce price competition that could create undue risks to the safety or the quality of care for patients.

6.2.1 Rules for local variations

251. For a local variation to be compliant with the national tariff, commissioners and providers must comply with the following rules.[64]

Rules for local variations

1. The commissioner and provider must apply the principles set out in Section 6.1 when agreeing a local variation.
2. The local variation must be documented in the commissioning contract between the commissioner and provider for the service to which the variation relates.
3. The commissioner must submit a written statement of the local variation to NHS Improvement using the local variations template.[65] NHS Improvement will publish the templates it receives on behalf of the commissioner.

64 The rules in this section are made under the 2012 Act, section 116(2).

65 Template available from: https://improvement.nhs.uk/resources/locally-determined-prices/. Please note: for the 2020/21 Covid-19 financial arrangements, a template local variation statement is available from www.england.nhs.uk/coronavirus/finance/. Any template published before publication of this NTPS, in accordance with the rules in the 2019/20 NTPS, will continue to be valid and does not need to be republished.

4. The deadline for submitting the statement is 30 days after the agreement.

252. Under the 2012 Act, commissioners must maintain and publish a written statement of any local variation.[66] They should publish each statement no later than 30 days after the variation agreement. These statements (which can be combined for multiple services) must include details of previously agreed variations for the same services.[67] Commissioners must therefore update the statement if they agree changes to the variations covered by the statement.

253. 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.[68] The completed template should be included in the commissioning contract (Schedule 3 of the NHS Standard Contract).

254. 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?

255. 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.

256. 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

66 2012 Act, section 116(3).
67 2012 Act, section 116(3)(b).
68 Available from: https://improvement.nhs.uk/resources/locally-determined-prices/

service with a national price (eg an HRG).[69] In practice, several services could be uneconomic as a result of similar cost issues.

257. 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.[70]
- 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.

258. 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.[71] To be approved or granted, NHS Improvement must be 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

259. NHS Improvement's method[72] 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[73] must be supported by sufficient evidence to enable NHS Improvement to determine whether a local modification is appropriate, based on our method.

69 Please note: the blended payments for emergency care, outpatient attendances and maternity services means that these services do not have national prices (see Section 7). This means that a local modification is not available for these services.

70 Submission templates can be found at: https://improvement.nhs.uk/resources/locally-determined-prices/
Please note: for the 2020/21 Covid-19 financial arrangements, a template local variation statement is available from www.england.nhs.uk/coronavirus/finance/. Any template published before publication of this NTPS, in accordance with the rules in the 2019/20 NTPS, will continue to be valid and does not need to be republished.

71 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.

72 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.

73 The 2012 Act, section 124(4), requires that an agreement submitted to Monitor must be supported by such evidence as Monitor may require.

260. 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.

261. 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).

262. 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

263. 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.
- 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 – PFI). 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 Financial Recovery Fund.[74]

264. 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).

6.3.4 Additional condition for local modification agreements

265. 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).[75]

[74] 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.

[75] 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)).

6.3.5 Additional conditions for local modification applications

266. 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 2019/20; 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)[76] 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[77] 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[78] 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 2020, unless there are exceptional circumstances (for example, where there is a clear and immediate risk to patients).

267. 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

268. 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,

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

77 Constructive engagement is also required by condition P5 of the provider licence, in cases where a provider believes that a local modification is required.

78 Submission templates can be found at: https://improvement.nhs.uk/resources/locally-determined-prices/

applications will be effective from the start of the following financial year, subject to any changes in national prices, to allow commissioners to take account of decisions in planning their budgets.

269. 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

270. The terms of a local modification agreement should be included in the relevant commissioning contract (using the NHS Standard Contract where appropriate)[79] 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.

271. 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)).

6.4 Local prices

272. 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.[80] We have set both

79 Providers and commissioners should refer to the latest available guidance on the NHS Standard Contract: www.england.nhs.uk/nhs-standard-contract.

80 2012 Act, section 116(4)(b) and (12) and section 118(5)(b).

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).

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

274. In addition, Section 7 sets out the separate rules for emergency care, outpatient attendances and maternity services (other than maternity services commissioned by NHS England). The rules in this Section 6 do not apply to those services.

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

276. Table 9 shows which rules apply to which area of activity.

Table 9: Application of local pricing rules

Rule	Section	Acute	Mental health	Community	Ambulance
1	6.4.1	✓	✓	✓	✓
2	6.4.1	✓	✓	✓	✓
3	6.4.2	✓	✓	✓	✓
4	6.4.2	✓	✓	✓	✓
5	6.4.3	✓	×	×	×
6	6.4.4	×	✓	×	×
7	6.4.4	×	✓	×	×
8	6.4.4	×	✓	×	×
9	6.4.4	×	✓	×	×
10	6.4.5	×	×	×	✓

6.4.1 General rules for all services without a national price

277. Rules 1 and 2 apply when providers and commissioners agree local prices for services without national prices (other than emergency care, outpatient attendances and most maternity services[81]). 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 cost uplift and efficiency factors for 2020/21 (as set out in Sections 4.7 and 4.8) when setting local prices for services without a national price for 2020/21.

278. We expect that locally determined prices are based on actual costs, and therefore not affected by changes to the MFF. However, where local prices are informed by the provider MFF, it may be appropriate for them to be adjusted for both the 2020/21 MFF values and the 0.38% adjustment to underlying prices noted in Section 5.2, paragraph 207.

6.4.2 General rules for services with a national currency but no national price

279. Services that have national currencies but no national price are:

- working-age and older people **mental health services** and **Improving Access to Psychological Therapies (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)

81 Rules 1 and 2 apply where maternity services are being commissioned by NHS England.

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.

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

281. The blended payment for emergency care in effect sets national currencies for emergency care, outpatient attendances and maternity services (see Section 7). However, this is not covered by rules 3 and 4 and Annex C.

282. The following rules apply when providers and commissioners are setting local prices for the services specified in paragraph 279.

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.[82]

(c) Providers must submit the completed templates within 30 days of the agreement.

82 Template available from: https://improvement.nhs.uk/resources/locally-determined-prices/ Please note: for the 2020/21 Covid-19 financial arrangements, a template local variation statement is available from www.england.nhs.uk/coronavirus/finance/. Any template published before publication of this NTPS, in accordance with the rules in the 2019/20 NTPS, will continue to be valid and does not need to be republished

(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,[83] 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.

6.4.3 High cost drugs, devices and listed procedures, and listed innovative products

283. A number of high cost drugs, devices and listed procedures and listed innovative products (see Section 3.4) are not reimbursed through national

83 Template available from: https://improvement.nhs.uk/resources/locally-determined-prices/ Please note: for the 2020/21 Covid-19 financial arrangements, a template local variation statement is available from www.england.nhs.uk/coronavirus/finance/. Any template published before publication of this NTPS, in accordance with the rules in the 2019/20 NTPS, will continue to be valid and does not need to be republished.

prices. Instead, they are subject to local pricing in accordance with rule 5 below. Annex A sets out the lists of excluded drugs, devices, procedures and innovative products for the 2020/21 NTPS – these are subject to local prices.

Local pricing rules: rules for high cost drugs, devices and listed procedures and listed innovative products

Rule 5

(a) As high cost drugs, devices and listed procedures and listed innovative products 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 and listed procedures and listed innovative products must be paid as well as the relevant national price for the currency covering the core activity. However, the price for the high cost drug, device, listed procedure or listed innovative product must be adjusted to reflect any part of the cost already captured by the national price.

(c) The price agreed should reflect:

i. in the case of a high cost drug for which a reference price has been set at a level to incentivise provider uptake of that drug, that reference price;
ii. in the case of a listed innovative produce for which a reference price has been set, that reference price;
iii. in all other cases, 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 high cost device, high cost drug or listed innovative product 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

284. 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 of these services must adhere to the requirements of rules 6 to 9.

285. 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.[84] 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; and

[84] Providers and commissioners can agree local variations from these rules if they meet the requirements of our rules on local variations.

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

286. This section sets out the rules for local price-setting for ambulance services with and without national currencies. In addition to rules 1 to 4, providers and commissioners of these services 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

287. 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.

288. 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

289. The rules on local price setting (as set out in Section 6.4.1 – 6.4.5) 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 2020/21, 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

290. 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 tariff 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).[85]

291. 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

292. 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.

293. 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.

294. Payment for community health services must adhere to the general rules set out in Section 6.4.1. This allows continued discretion at a local level to determine payment approaches that support high quality care for patients on a sustainable basis.

295. Where providers and commissioners adopt alternative care pathway payment approaches that result in the bundling of community health services with services covered, at least in part, by national prices, the local variations rules must be followed in respect of those nationally priced services (see Section 6.2).

296. NHS England and NHS Improvement and NHS Digital are testing new currency models for community healthcare, which could be used to support

[85] These are arrangements made under the NHS Act 2006, section 3 or 3A.

future funding for these services. These models focus on five currency areas: children and young people with disabilities; single episodes of care; long-term conditions; frailty; last year of life.

7. Rules for services covered by blended payments

297. This Section sets out the rules for the pricing of emergency care, outpatient attendances and maternity services.[86] Each set of rules provides for a "blended payment" for the services in question. However, in the case of maternity services, commissioners and providers have a choice between a blended payment or a care pathway payment for 2020/21.

298. The rules here do not apply to the blended payment for adult mental health services. See instead local pricing rule 7 in Section 6.4.4.

299. The rules specified in this section are supported by the *Guidance on blended payments* document, which includes general information about blended payments, more detailed guidance and some worked examples.

7.1 Blended payment for emergency care

300. The 2019/20 NTPS introduced a blended payment for emergency care 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.[87]

301. Further detailed guidance is available in the supporting document *Guidance on blended payments*.

86 Except maternity services commissioned by NHS England, which remain subject to the rules in Section 6.4

87 The rules are essentially unchanged from the 19/20 NTPS, so a blended payment agreed under the NTPS prior to the publication this NTPS should continue to apply under the 20/21 rules without modification

302. The blended payment means emergency care services are not in the scope of national prices. Providers and commissioners must, however, apply the rules set out here to agree the amounts payable for emergency services.

303. Where local health systems have already moved – or in future agree to move – to a different payment system, they can use the provision in the rules for local departure from the default approach (see rule 6) to maintain or adopt the alternative payment approach.

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 England and NHS Improvement in relation to the pricing of those services.

b) Subject to rule 2(d)(ii), 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[88]);
ii. emergency admission excess bed days;
iii. A&E attendances at Type 1, 2 and 3 A&E facilities, including urgent treatment centres where they are classified as a Type 3 A&E service;
iv. all same day emergency care activity, even if this activity is being coded as something other than an emergency admission or A&E attendance[89]

and includes activity that was outside the scope of national prices in 2018/19 and does not have an HRG price specified in Annex A, 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;

88 Please see the NHS Data Dictionary for more details www.datadictionary.nhs.uk/data_dictionary/attributes/a/add/admission_method_de.asp

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

ii. all unbundled elements, such as critical care spells associated with emergency admissions and high cost drugs and devices.

e) In rules 2 to 4, “commissioner” does not include NHS England.[90]

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 2020/21, or
ii. a commissioner and provider accept that such services are to be provided by the provider (for the benefit of persons for which the commissioner is responsible) during some or all of that year without such a contract being in place

the price payable for those services must be determined by reference to the value of planned activity.

b) The ‘value of planned activity’ is the value agreed by the commissioner and provider.

c) The commissioner and provider must agree the value on the following basis:

i. determine the planned level of activity to be provided by the provider for the commissioner; and
ii. calculate the value of that planned activity using the unit prices and expected casemix.

d) The ‘unit price’ for each individual service is:

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

[90] NHS England commissioning activity is subject only to rule 5 (services outside the blended payment).

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 in accordance with the local pricing rules in Section 6.4.1.

Rule 3 (the blended payment)

a) Subject to paragraph (f), if the value of planned activity for the financial year 2020/21 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:

   i. to emergency services commissioned by NHS England; and
   ii. to emergency services commissioned by a CCG, if the commissioner and provider have agreed or accept as referred to in rule 2(a) and the value of planned activity for the financial year 2020/21 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 (d), the price payable shall be:

   i. subject to sub-paragraph (ii), the unit price for that service as defined in rule 2(d) above, or
   ii. if the relevant conditions are satisfied, the BPT price for that service (varied in accordance with the national variations specified in Section 5, as if that price were a national price for that service).

d) 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 the 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,[91] 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.

7.2 Blended payment for outpatient attendances

304. For the 2020/21 NTPS we are introducing a blended payment for outpatient attendances to support a more effective approach to resource and capacity planning for these services and to better support innovative ways of working.

91 Template available from: https://improvement.nhs.uk/resources/locally-determined-prices/ Please note: for the 2020/21 Covid-19 financial arrangements, a template local variation statement is available from www.england.nhs.uk/coronavirus/finance/. Any template published before publication of this NTPS, in accordance with the rules in the 19/20 NTPS, will continue to be valid and does not need to be republished

The calculation of the blended payment is determined in accordance with the pricing rules set out below.

305. Further detailed guidance is available in the supporting document *Guidance on blended payments*.

306. The introduction of blended payment removes outpatient attendances from the scope of national prices. Providers and commissioners must, however, apply the rules set out here to agree the amounts payable for outpatient attendances.

307. Where local health systems have already moved – or in future agree to move – to a different payment system, they can use the provision in the rules for local departure from the default approach (see rule 5) to maintain or adopt the alternative payment approach.

Rule 1 (general rule)

a) Commissioners and providers must determine the prices payable for the provision of outpatient attendances in accordance with rules 2 to 5 below and having regard to guidance published by NHS England and NHS Improvement in relation to the pricing of those services.

b) Subject to rule 2(d)(ii), the local pricing rules specified in Section 6.4 do not apply to outpatient attendances.

c) 'Outpatient attendances' means:

i. All outpatient activity that groups to a WF* HRG, when grouped with the local payment grouper, that are a result of:
   - no procedure(s) being recorded
   - only procedures ignored for grouping being recorded
   - only codes from OPCS category X62 Assessment being recorded; and

ii. advice and guidance services related to this activity.

d) For the purposes of the blended payment, outpatient attendances excludes:

i. diagnostic imaging (TFC 812);

ii. outpatient procedures which do not generate a WF* HRG when grouped with the local payment grouper, or those that only group to a WF* 'alternate' HRG in SUS+ secondary processing;
iii. activity in scope of the maternity services blended payment;
iv. activity in scope of the emergency care blended payment;[92] and
v. activity in scope of the cystic fibrosis pathway payment.

e) Rules 2 and 3 do not apply to services commissioned by NHS England other than specialised services.

f) In these rules, "the payment period" means the period from the date of publication of this 2020/21 NTPS to the end of the financial year 2020/21.

Rule 2 (agreeing activity levels)

a) Where:

i. a commissioner contracts with a provider for the provision of outpatient attendances for the financial year 2020/21, 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 provided during the payment period must be determined by reference to the value of planned outpatient activity.

b) The 'value of planned outpatient 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 outpatient activity to be provided by the provider for the commissioner;
ii. calculate the value of that planned outpatient activity using the unit prices and expected casemix; and

[92] This may include same day emergency care activity which is being coded as an outpatient attendance.

iii. adjust the value to reflect the agreed expected level of best practice attainment (ie compliance with the conditions for best practice tariffs).

d) Subject to paragraph (e), 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 the national variations specified in Section 5, as if that unit price were a national price for that service,
ii. if there is no such unit price, the amount agreed between the commissioner and provider, subject to the local pricing rules in Section 6.4.1.

e) For the purposes of calculating the value of planned outpatient activity, where activity delivered as a face-to-face attendance in 2019/20 (and generating a WF01A, WF01B, WF02A or WF02B HRG) is planned to be delivered as a non-face-to-face attendance in 2020/21 (and generating a WF01C, WF01D, WF02C or WF02D HRG), the commissioner and provider must use the corresponding unit prices for face-to-face attendance.

Rule 3 (the blended payment)

a) If the value of planned outpatient activity for the financial year 2020/21 is £4 million or more for CCG commissioned activity, or any value for NHS England commissioned specialised activity,[93] the price payable to the provider shall be a price for all the outpatient attendance services provided during the payment period calculated in accordance with the following paragraphs.

Fixed payment

b) The price payable shall be the value of planned outpatient activity for the payment period plus the amount for advice and guidance services as referred to paragraph (c) ("the fixed payment"), subject to any adjustments referred to in paragraphs (d) to (f).

c) If the commissioner and provider agree to operate an advice and guidance service delivered by the provider for patients for whom the commissioner is responsible, an amount to be paid for that service for the payment period must

[93] Rules 2 and 3 do not apply to other NHS England commissioned activity.

be agreed between commissioner and provider in accordance with the local pricing rules in Section 6.4.1.

Risk share

d) The commissioner and provider may agree risk share arrangements when agreeing the value of planned activity and unit prices, which make provision for cases where the price payable is to increase or decrease by reference to the extent to which the value of actual activity varies from the value of planned level of activity. If the value of actual activity for the payment period is more or less than any amount agreed by the commissioner and provider under any such risk share arrangements, the fixed payment shall be increased or decreased in accordance with those arrangements.

Quality or outcomes

e) The commissioner and provider must agree quality or outcomes measures in relation to advice and guidance services (see rule 3(c)) and in relation to such other matters connected with outpatient services as they consider appropriate, at the time of agreeing the value of planned activity and unit prices. The fixed payment must be adjusted by reference to the extent to which the provider has achieved or not achieved those outcome measures, in accordance with the terms agreed by the commissioner and provider

Best practice attainment

f) The fixed payment may be adjusted by reference to whether the provider has not achieved or has exceeded the agreed expected level of best practice attainment, in accordance with arrangements agreed by the commissioner and provider at the time of agreeing the value of planned activity and unit prices.

Rule 4 (services outside the blended payment)

a) This rule applies:

i. to outpatient services commissioned by NHS England other than specialised services; and

ii. to outpatient services commissioned by a CCG, if the commissioner and provider have agreed or accept as referred to in rule 2(a) and the value of planned activity for the financial year 2020/21 is less than £4 million.

b) Where this rule applies, the prices payable for outpatient attendance services shall be:

i. subject to sub-paragraph (ii), the unit prices for those services as defined in rule 2(d);
ii. if the relevant conditions are satisfied, the BPT prices for those services (varied in accordance with the national variations specified in Section 5, as if that price were a national price for that service); or
iii. in the case of advice and guidance services, the payment referred to in rule 3(c).

Rule 5 (local departures)

a) A commissioner and provider may agree to depart from the pricing arrangements for outpatient attendance services specified in rules 2 to 4, if they comply with the requirements in paragraphs (b) to (f) 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 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 the outpatient services in question.

d) The commissioner must maintain and publish a written statement of the agreement, using the template provided by NHS England and NHS Improvement,[94] 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.

[94] Template available from https://improvement.nhs.uk/resources/locally-determined-prices/ Please note: for the 2020/21 Covid-19 financial arrangements, a template local variation statement is available from www.england.nhs.uk/coronavirus/finance/. A template published before publication of this NTPS, under the rules in the 2019/20 NTPS, will continue to be valid and does not need to be republished.

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.

7.3 Payment rules for maternity services

308. Maternity services continue to be outside the scope of national prices.[95] The pricing of maternity services must be determined by CCGs and providers in accordance with the rules set out below.

309. Services commissioned by NHS England, including Specialised Commissioning, are not covered by these rules.

310. For the 2020/21 NTPS we are introducing a blended payment for maternity services to support a more effective approach to resource and capacity planning for these services and to better support innovative ways of working.

311. Further detailed guidance is available in the supporting document *Guidance on blended payments.*

312. Providers and CCGs have the option to continue using the existing maternity pathway payment approach for 2020/21 (see rule 2).

313. Where local health systems have already moved – or in future agree to move to – a payment system other than the blended payment or the pathway payment, they can use the provision in the rules for local departure from the default approach (see rule 6) to maintain or adopt the alternative payment approach.

Rule 1 (general rule)

a) Commissioners and providers must determine the prices payable for the provision of maternity services in accordance with rules 2 to 5 below and

[95] Maternity services were removed from the scope of national prices in the 2019/20 NTPS, with maternity prices being made non-mandatory to address an issue with the pricing of public health services

having regard to guidance published by NHS England and NHS Improvement in relation to the pricing of those services.

b) The local pricing rules in Section 6 do not apply to maternity services to which these rules apply.

c) Maternity services means:

i. all antenatal care
ii. all birth episodes
iii. all postnatal care provided to a mother and her well baby by midwifery teams before discharge to primary care.

d) These rules do not apply to maternity-related services commissioned by NHS England.

e) e) In these rules, “the payment period” means the period from the date of publication of this 2020/21 NTPS to the end of the financial year 2020/21.

Rule 2 (payment approach)

a) A commissioner and provider of maternity services for the payment period must agree payment on the basis of a blended payment or a maternity pathway payment, unless they agree a local departure in accordance with rule 6.

b) Under a blended payment approach, commissioners and providers must determine the price payable for maternity services in accordance with rules 3 to 5, having regard to guidance published by NHS England and NHS Improvement in relation to the blended payment approach for those services.

c) Under a maternity pathway payment approach, commissioners and providers must determine the prices payable for maternity services in accordance with the supporting document, *Guidance on the maternity pathway payment*.

Rule 3 (agreeing activity levels for blended payments)

a) Where:

i. a commissioner contracts with a provider for the provision of maternity services for the financial year 2020/21, or
ii. a commissioner and provider accept that such services are to be provided under the responsibility of that the provider (for the benefit of persons for which the commissioner is responsible, and whether those services are provided directly by that provider or by other providers in the Local Maternity System) during some or all of that year without such a contract being in place,

the price payable for those services during the payment period 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 by reference to the unit prices and expected casemix.

d) The 'unit price' for each individual service is the unit price for the service in question agreed by the commissioner and provider (whether specified as a pathway of care or an individual HRG), having regard to any non-mandatory prices for maternity services included in the supporting *Non-mandatory prices* workbook.

Rule 4 (the blended payment)

Fixed payment

a) The price payable to the provider for maternity services provided during the payment period shall be the value of the planned activity for that period, subject to paragraphs (b) to (d).

Risk share

b) The commissioner and provider may agree risk share arrangements when agreeing the value of planned activity and unit prices, which make provision

for cases where the price payable is to increase or decrease by reference to the extent to which the value of actual activity varies from the value of planned level of activity. If the value of actual activity for the payment period is more or less than any amount agreed by the commissioner and provider under any such risk share arrangements, the price payable shall be increased or decreased in accordance with those arrangements.

Quality or outcomes

c) The commissioner and provider must agree quality or outcomes measures in connection with the blended payment for the payment period, at the time of agreeing the value of planned activity and unit prices.

d) The price payable may be adjusted by reference to the extent to which the provider has achieved or not achieved those quality or outcome measures, in accordance with the terms agreed by the commissioner and provider.

Rule 5 (services outside the blended payment)

a) The blended payment specified in rules 3 and 4 does not apply to services provided to patients the commissioner is responsible for, but which are provided outside the Local Maternity System or agreed planning boundary.

b) In such cases, the commissioner and the provider must determine the price payable using the prices published in the *Non-mandatory prices* workbook as a guide.

Rule 6 (local departures)

a) A commissioner and provider may agree to depart from the pricing arrangements for maternity services specified in rules 2 to 4, if they comply with the requirements in paragraphs (b) to (f), which are intended to mirror the requirements for agreeing a local variation for a service with a national price, set out in Section 6.2.

b) The commissioner and provider must apply the local pricing principles in Section 6.1.

c) The agreement must be documented in the NHS Standard Contract between the commissioner and provider that covers maternity services.

d) The commissioner must maintain and publish a written statement of the agreement, using the template provided by NHS Improvement,[96] 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.

[96] Template available from https://improvement.nhs.uk/resources/locally-determined-prices/ Please note: for the 2020/21 Covid-19 financial arrangements, a template local variation statement is available from www.england.nhs.uk/coronavirus/finance/. Any template published after before publication of this NTPS, in accordance with the rules in the 2019/20 NTPS, will continue to be valid and does not need to be republished.

8. Payment rules

314. 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).[97]

8.1 Billing and payment

315. 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

316. For NHS activity where there is no national price, providers must adhere to any reporting requirements set out in the NHS Standard Contract.

317. For services with national prices, providers must submit data as required under SUS guidance.[98]

318. The dates for reporting activity and making the reports available will be published on the NHS Digital website.[99] NHS Digital will automatically notify subscribers to its e-bulletin when these dates are announced.

319. 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[100] about these conditions and sets the actions that CCGs, CSUs and providers must take to ensure they act lawfully.

97 2012 Act, section 116(4)(c).
98 https://digital.nhs.uk/services/secondary-uses-service-sus/secondary-uses-services-sus-guidance
99 https://digital.nhs.uk/services/secondary-uses-service-sus/payment-by-results-guidance
100 See: www.england.nhs.uk/ig/in-val/invoice-validation-faqs/

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