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This response specifically relates to the proposed changes to cardiothoracic transplant services.

The relevant sections of the consultation documentation are as follows,

Annex DpA – NHS Payment Scheme prices workbook, 2023-24 – Tab 8 Other Guide Prices

Annex DpB – Guidance on currencies – Section 16 Cardiothoracic Transplant 280-294

The response is being submitted by the NHSBT Cardiothoracic Transplant Patient Group (CTPG) Chair on behalf of the patient population.

General Comments

An appropriate mechanism for the payment to providers for cardiothoracic transplant services is essential to ensure providers can deliver high quality sustainable services.

The CTPG supports the general principle of national tariffs for cardiothoracic transplant services as this mechanism will facilitate the improvement of services by incentivising efficiency. Specifically, it will financially reward providers who Improve organ utilisation rates and increase transplant numbers.

The CTPG does however have several concerns about the proposed payment scheme for cardiothoracic transplant, as follows,

1) **Lack of granularity which could lead to patients with certain protected characteristics (and the providers that treat them) being disadvantaged.**

The proposal of single tariffs for heart and lung transplants do not have the granularity to account for underlying case mix and hence complexity differences between different patient groups and the providers that may treat above average proportions of more complex patients.

The consultation process includes an Equality Impact Assessment (2023/25 NHS Payment Scheme – a consultation notice. Part C Impact Assessment, Section 4). This document includes the following statement.

“The HRG4+ phase 3 currency design enables us to distinguish between care provided to patients with different levels of complexity to reflect the expected higher use of resources to treat patients who do have complications and comorbidities. Comorbidities can be associated with disability, and therefore this currency design helps to ensure that providers are more appropriately reimbursed for providing care to patients with disabilities. We are not aware of any other information that would suggest that the 2023/25 NHSPS proposals would have a disproportionate impact on this group of patients”. (Section 4.3.8)

By using single “package” tariffs for heart and lung transplant the benefit of the currency design which is intended to account for case mix differences is lost. As such the proposed cardiothoracic transplant tariff may discriminate between patients with protected characteristics.

There is sufficient evidence within the publicly available information to suggest this is indeed the case.

For example, previous open-heart surgery is a known risk factor for heart transplantation as it leads to longer waiting times (due to higher antibody presence), increased surgical

complexity and prolonged recovery times. These are all key drivers of cost. Reimbursement of heart transplants at a single tariff will disadvantage providers who treat an increased proportion of these patients. Analysis of the last 3 reported years transplant registrations show a range between providers from 18% to 57% of patients who have had previous open-heart surgery.

NHS England must conduct a full equality impact assessment of the proposed tariffs for heart and lung transplant to ensure that they do not discriminate against any protected characteristic. Discrimination could occur where a provider treats an above average proportion of the case mix with a specific disability that is associated with increased complexity. This equality impact exercise needs to be developed in collaboration with clinical and patient representatives.

2) Over emphasis on quantity, and a lack of commissioning for quality

The CTPG supports the aim of proposals to increase organ utilisation and transplant rates as there is unmet need evidenced by high waiting list mortality and poor transplant rates in comparison to much of the developed world.

However, the CTPG would emphasise the need to also ensure payment mechanisms for cardiothoracic transplant, encourage and reward quality. With quality being assessed by multiple metrics, such as multi professional resourcing levels, mortality, morbidity and patient reported outcomes and experience.

The CTPG would support the development of best price tariffs on this basis and would welcome the opportunity to engage in this process.

3) Impact of changes at a provider level

The significant change of funding mechanisms for cardiothoracic transplant are likely to have a negative financial impact on some providers. This has the potential to reduce quality of care provided by those centres. The CTPG would recommend that any providers with financially negative impacts are “cushioned” with a multi-year transition period to ensure that providers can reengineer services without having a negative impact on patient care.

4) Lack of recognition of the financial impact of extreme cost patients

The costs of providing any acute service are significantly impacted by a small number of extreme cost patients. For cardiothoracic transplantation, costs will be largely driven by extreme lengths of stay, especially those in critical care facilities. The general construct of the payment mechanism recognises this by each HRG having a trim point (with excess bed days charged in addition) and critical care bed days being charged separately. The consultation document suggests that cardiothoracic transplant is a fixed package price. This is in direct contrast to the general principle of payment mechanisms for the overwhelming majority of other services and is especially concerning in high cost, high complexity, low volume activity such as cardiothoracic transplant.

5) Lack of acknowledgement and potential impact of services commissioned by NHSBT

The providers ability to deliver cardiothoracic transplant is entirely dependent on the retrieval of organs which are commissioned by NHSBT. If there were any significant changes in this provision it would impact on the providers ability to deliver transplant activity, and hence the funding they receive. Such examples could include the change in funding and hence

provision of technologies to support organ retrieval such as the Organ Care System (OCS) for heart transplants and ex-vivo lung perfusion (EVLP) for lung transplants.

The CTPG consider that increased integration and collaboration in commissioning transplant services between NHSBT and NHSE would lead to improved patient outcomes.

6) Lack of congruency with national strategic aims in organ transplantation

The commissioning documentation references strategies which are out of date and have been superseded. Taking Organ Donation to 2020 has been replaced by Organ Donation and Transplantation 2030: Meeting the Need.

The updated strategy has a specific objective to ensure "recipient and transplant outcomes will be amongst the best in the world". It is known that the UK outcomes do not compare favourably with comparable countries. For example, comparing UK adult heart transplant median survival and conditional survival against worldwide data from the International Society for Heart and Lung Transplantation the UK is below the average (N Onwuka & S Rushton, NHSBT, 2022).

The CTPG believes that NHS England need to ensure that tariffs are uplifted from the current cost basis to enable providers to deliver services which meet the strategic aim in terms of outcomes.

7) Appropriate funding for patients with VADs who do not proceed to transplant.

The CTPG recognise that long term VADs are solely commissioned as a bridge to transplant / decision. However, there will always be some patients with a long term VAD who never proceed to transplant.

The CTPG are concerned that this patient group will be disadvantaged as there is no clear funding stream for providers to provide the complex ongoing care they require. There are currently approximately 300 patients in the country with long terms VADs with nearly half of these not on the transplant waiting list. This number is likely to grow further and hence the lack of direct funding for this patient group will grow larger.

8) Low follow up tariff

The guide price annual follow up tariff of £2,388 (before MFF) appears to be extremely low. The closest comparable lifelong tertiary follow up service is cystic fibrosis. The lowest complexity (CYF1_) annual follow up tariff in cystic fibrosis is £5,762. The description of the expected specialist centre interaction with this complexity of patients is minimal (approx. 2 outpatient appointments per year).

The required annual follow up after cardiothoracic transplant is extremely variable but the very minimum levels would probably be comparable to the lowest complexity cystic fibrosis patients. The proposed single cardiothoracic transplant follow up tariff does not seem credible as it is less than half the lowest complexity cystic fibrosis follow up tariff.

As an example, in 2023 the CTPG worked with the Psychology Association for Cardiothoracic Transplant to investigate whether the provision of specialist psychology services met patient's needs.

The report demonstrated that in most centre's the patient's psychological needs were not being met (CTPG June 2022, Burns & Malpus).

Transplant centres have cited insufficient funding as a key factor.

In summary, CTPG does not believe the proposed annual follow up tariff is sufficient to enable units to deliver safe, high quality lifelong post-transplant care.

9) Potential to further disincentivise lung transplant in comparison to heart transplant

It has been reported that due to capacity constraints centres sometimes proceed with a heart transplant when they have also been offered donor lungs (Onwuka & Rushton, CTAG Lungs Sept 2022).

Most heart transplants undertaken are to patients in hospital, whilst most lung transplants undertaken are to patients waiting at home. Each day that a patient waits in hospital the cost to the provider increase. As the proposed transplant tariff reimburses a fixed amount per transplant there is a financial incentive for a provider to reduce in hospital pre transplant waits.

If a provider is faced with the choice between proceeding with a lung transplant for a patient waiting at home reimbursed at £92,584 (plus MFF) or a heart transplant for an in hospital patient reimbursed at £118,337 (plus MFF), from a purely financial perspective the heart transplant is the logical choice.

The CTPG is concerned that the proposed reimbursement mechanism of a fixed price inclusive tariff will further disadvantage lung transplant patients.

Specific Comments

The following comments relate specifically to the information provided on the proposed cardiothoracic transplant payment mechanisms within the consultation documentation.

1) Clarification over marginal rates (reference 282)

Section 282 states “the proposed currency and marginal payment rate”. The word marginal implies that payments for additional (or reduced) activity units would be reimbursed at a figure less than 100%. NHS England Highly Specialised Services Team stated that reimbursement would be 100%. Please could this be clarified.

2) Lack of clarity and inconsistency over what is included and excluded from transplant tariffs? (references 292 & 294)

Section 292 states that included in the transplant tariff is “patient assessment and immediate post operative care”, whilst in section 294 it states “immediate transplant preoperative care, post-transplant critical care”

These statements are clearly not fully aligned. There are so many potential different elements of care in the cardiothoracic transplant pathway across numerous points of delivery, and specific detailed guidance is required.

Failure to provide this and ensure congruency with the construct of the tariff will lead to local interpretation. It also has the potential to under resource Trusts which will lead to the inability to provide services.

3) Lack of information over what is included and excluded from the annual follow up tariff (reference 294)

The consultation document provides no information or guidance on what activity should and should not be included in the follow up tariff.

Failure to provide this and ensure congruency with the construct of the tariff will lead to local interpretation. It also has the potential to under resource Trusts which will lead to the inability to provide services.

4) **Lack of information on the reimbursement mechanisms for patients who do not proceed to transplant.**

There will inevitably be several patients who transverse some of the transplant care pathway but never proceed to transplant. The consultation document gives no information or guidance on how providers are reimbursed for these patients.

Failure to provide this and ensure congruency with the construct of the tariff will lead to local interpretation. It also has the potential to under resource Trusts which will lead to the inability to provide services.

Summary

Whilst several concerns have been raised, the CTPG believe these could all be appropriately addressed by sufficient consultation with clinical, provider and patient representation.

The CTPG support the proposed direction of travel which is a payment mechanism that facilitates efficiency and increased transplantation. It would however like to see a greater emphasis on quality.

It believes that the proposed tariff needs to have a greater degree of granularity to ensure that providers delivering services to patients from all backgrounds are sufficiently reimbursed.