

Submitted to: pricing@improvement.nhs.uk

NHS Clinical Commissioners

The independent collective voice
of clinical commissioners

NHS Clinical Commissioners response payment system reform proposals for 2019/20

Monday 29 October 2018

I. NHS Clinical Commissioners

NHS Clinical Commissioners (NHSCC) is the membership body of Clinical Commissioning Groups (CCGs). Established in 2012, we have over 91% of CCGs in membership. We offer a strong national voice for our members on specific policy issues and support them to be the best they can to commission services effectively for their local populations.

Our response has been developed based on member feedback gathered from a variety of sources. These include discussions at the Tariff Advisory Group meetings, of which NHSCC is a member, calls with the NHSCC Finance Forum (the representative group for CCG Chief Finance Officers), outputs from webinars with the NHS Improvement and NHS England pricing team on the proposed approach, and a workshop to discuss the blended payment proposals. We welcome the opportunity to respond and are keen to support further engagement with our members as the proposals are finalised.

II. Overall comments on payment reform

On behalf of our members, NHSCC has highlighted for some time that the payment system is one of the biggest barriers to further integration of health and care and the development of truly collaborative local approaches to both planning and delivery that will improve population outcomes. We believe that any reforms must reduce the potential for conflict and arbitration and instead local systems should be incentivised to work in a collaborative manner for the benefits of local populations. Most recently we have produced a series of enabling asks to support integration across “System” and “Place” one of which focussed on payment reform:



3. Revise the sections [of the Health and Social Care Act 2012] that describe how payment for care will be made so that the payment system is changed to reflect the move towards integration and collaboration across NHS providers within a place. This would include replacing the default to Payment By Results (PBR) tariff with a mandate for commissioners and providers to mutually agree a contract form with no default. If they can't agree a contract then there is no default position. This should be viewed as a measure of system maturity and mutual agreement should be the expectation, but if necessary could, by exception, be enforced by:

- Making PSF and CCG uplift conditional on reaching agreement
- An increase in arbitration fines to both parties to avoid this becoming the new default and to ensure there is a compelling incentive to reach agreement
- Awarding new long term plan funding based on systems being able to reach agreement.

We welcome the payment reforms outlined in the document as being a welcome step towards supporting integrated health and care delivery models. Overall, however, we are disappointed that NHS Improvement and NHS England have not gone further to ensure that the payment system supports the new approach that providers and commissioners are expected to adopt.

1. Specific comments on the proposals

a. Duration of the tariff

In 2016 we were supportive of the introduction of a multi-year tariff for 2017/18 – 2018/19 as this offered “an opportunity for the system to plan effectively to meet the needs of local populations over the longer term. Commissioners will benefit from the certainty that multi-year planning offers allowing them to focus on re-designing services to better meet the needs of patients and populations.”

However, given the shifting landscape within the NHS, the development and release of the long-term plan, and requirements for STPs to undertake a further planning process, we agree that setting a one-year tariff is appropriate.

Furthermore, our members inform us that they are increasingly developing local payment systems that move away from a system based upon payment by results and tariff prices, including moving to blended systems as described below and block contracts. Therefore, whilst having national reference prices for the cost of services is vital, greater flexibility in applicability of the payment system locally, with freedom for systems to develop their own approaches, rather than the application of rigid national approaches, more effectively supports system integration. There is considerable work undertaken nationally to develop processes and systems within the payment system which might be better deployed in supporting local systems to develop approaches that make sense within their local context, whilst having regard to national priorities.

b. A blended payment approach for emergency care

We welcome proposals by NHS England and NHS Improvement to support greater integration and move away from payment systems that focus on individual organisations and instead seek to incentivise system working. The blended payment approach outlined for emergency care is based upon structures that local systems have developed and that have proved successful. We welcome any attempt to reduce the continued rise in emergency admissions and costs.

From discussions with our members there are three key requirements for any new payment system; firstly, that it supports collaborative and system working; secondly, that it reduces the administrative and associated cost burden for both commissioners and providers; and finally, that it takes into account the differing levels of development of local systems, some having developed and implemented similar approaches for a long period of time, whilst others struggle to have effective conversations on basic collaborative issues.

We believe that the outlined blended payment approach could support increased collaborative working, with a focus on what the local system as a whole can support to deliver the most efficient and effective quality of health and care outcomes. Importantly, this also allows for the sharing of risk for increases in acute activity and the benefits of any reduction in that same activity. However, there are a number of practical considerations that need to be addressed for this to work in practice and further testing undertaken to ensure that the system is robust for implementation in 2019/20.

From review of the suggested approach we are concerned that there is potential for this to increase the bureaucratic and administrative burden on local systems. The system must be kept as simple as possible, with national defaults established if local areas fail to reach agreement to avoid disagreement and extended contractual disputes between providers and commissioners. These defaults should be mathematically sound and tested with commissioners and providers.

By ensuring that the blended payment approach is the default position, this will support local systems that have not yet made progress on collaborative payment approaches to do so, whilst allowing those areas that have agreed their own local approaches to go further.

Our members view is that this should be the default approach for the national bodies, allowing local systems the freedom to develop if they are able to do so or already have but also ensuring that no system is left behind.

Baselines

Central to the success of the approach will be the agreement of the baseline costs from which the 2019/20 elements will be drawn. There are several issues that need to be addressed: firstly, what is in scope of the approach and how emergency care is being defined e.g. ambulatory care, excess bed days, etc.; secondly, the incentive for providers to set a high figure whilst commissioners would want to agree a low figure, which may drive both further apart and increase potential conflict; thirdly, whether this is set on activity or cost as by setting a baseline that is under in activity and over on price, transactional costs won't be reduced; fourthly, the year from which the baseline should be determined; and finally that the regulatory approach to baseline calculations within local

systems must be collaborative, taking a whole system view, rather than pushing the provider to take one approach and the commissioner to take another.

Ambulatory care

Ambulatory care should be included within a payment system covering emergency care. To do so, our members view is that ambulatory care currencies should be developed. These are reported and costed differently across the country, and the lack of a national approach leads to some perverse behaviours by both commissioners and providers. Furthermore, the introduction of national currencies would allow commissioners to understand more clearly what is happening in their local area, better define the activity, improve development of patient pathways and understand the impact of transformative approaches.

Cost neutrality of removal of Marginal Rate Emergency Tariff (MRET)

The removal of MRET must be cost neutral for commissioners at an individual level. Indeed, our members have made us aware of many schemes where the savings from MRET has been reinvested in local community or other out-of-hospital services which would be jeopardised if additional funding was not provided. If an adjustment is made to national rather than individual allocations, then this will miss the different local approaches that have been introduced, or those areas that have abandoned MRET entirely.

Price and costs

The recent announcement by Ian Dalton, chief executive, NHS Improvement that £1bn of Provider Sustainability Funding (PSF) will be diverted into the urgent and emergency tariff signalled recognition that the set prices in the tariff do not reflect the actual costs of delivering services. Our members have reported the increasing burden that the lack of accuracy within prices places on their local provider. However, how this is delivered will require further consideration. Many areas have now moved away from the tariff as a system for reimbursing urgent and emergency care therefore there is a risk that funding allocated in this way will not reach all providers. It would be helpful to understand what adjustments will be made to CCG allocations to reflect this additional funding. The proposal needs to recognise the difference between the tariff price and the actual costs.

Comments on the proposals for feedback

1. Option B of the outlined approaches would support reduced contractual negotiations, thereby reducing administrative burden, whilst setting a national default for both payment elements. This would allow local systems to utilise their own local approaches where this has been agreed, whilst ensuring that those systems further behind are supported to implement the approach
2. Additional activity within a defined tolerance should be determined at a national level, with the ability for local systems to vary this if they can reach agreement. The “break glass point” introduces an unnecessary level of complexity and should be removed.
3. On the level of activity, a national default should be in place for each contracting round with commissioner and providers able to agree to move away from this where appropriate.

Concluding statements on the blended payment approach

We support the overall approach that NHS Improvement and NHS England have outlined. However, to be fully supportive of the scheme as described several issues need to be addressed as outlined above. We are particularly concerned that CCG allocations need to be adjusted effectively to implement this approach, and that adequate funding is available to cover any potential increase in costs. Significantly, the policy intention of the approach must be clearly outlined and assurance undertaken that this is having the desired impact of reducing inappropriate non-elective care.

The proposals were explored in greater detail during a workshop hosted by NHS England and NHS Improvement and we would like to express our members gratitude for offering the opportunity to provide direct feedback on the development of the system. Our members would be keen to be involved in any further engagement work as the proposal is refined.

c. Outpatient attendances

Our members support any attempts to reduce face-to-face consultant led outpatient attendances where this is clinically appropriate. Indeed, many areas are already developing their own local approaches that address this issue. In developing an updated payment mechanism, it will be important to understand whether the system finds the suggested approach valuable. It would be useful to understand, within the final tariff document, how the national prices set in the 2017/19 National Tariff Payment System were utilised by the local systems and what impact these had on reducing inappropriate attendances.

d. Market Forces Factor (MFF)

As the national representative organisation for CCGs, we support attempts to ensure that the data on which national prices are based is accurate and up-to-date. We agree that the MFF needs to be updated and welcome the approach to phasing to allow the system to adjust to these changes.

However, we are concerned about the impact that this will have during a period of considerable organisational change and when we are seeking to transform the way in which health and care is delivered. The proposed adjustment will have a major impact on urban centres that are also experiencing the highest growth in population under current models. We believe that this jeopardises the potential for the long term plan to be delivered in these areas as this will cause a minimum of six years of financial impact – four years phasing and two years landing, with possibly greater permanence following allocation adjustments. This would focus these areas on delivering cost savings rather than transformation and may also limit the ability of local systems to work collaboratively. Further background must be provided to the policy decision-making that will result in significant impact on these areas compared to the rest of the country along with the methodology and input assumptions used to make the calculations. We would also note that no overall cost savings to the NHS will be delivered following this adjustment and indeed it is more likely to increase overall costs, as those areas that gain will, rightly, spend the additional funding, whilst those areas that lose will find it challenging to reduce costs significantly.

Finally, there remain two issues that need further consideration; firstly, what the management will be for provider ‘winners’ and ‘losers’, especially as the overall cost base will not reduce; and

secondly, that this must be clearly reflected in CCG allocations with a necessary adjustment made outside of any distance from target (DFT) allocation adjustments.

e. Maternity pathway

Following the experience of the introduction of the more granular HRG4+ payment system in the previous National Tariff Payment System, with significant increased reporting of more complex patients with associated higher costs, our members are concerned about the introduction of any more granular system of payment. In our experience if NHS Improvement and NHS England make it possible for more complex work to be rewarded better then there is a surge in more complex cases. This may be due to a variety of different factors, but NHS Improvement and NHS England must factor this into the introduction of either payment level system, potentially by releasing additional funding to commissioners that experience the greatest increase in costs.

f. Other payment reform proposals

We believe that the best approach is seeking to move along local systems which are further behind in effective development and implementation, whilst allowing local systems that have made progress to go further. This principle (as outlined above) should be used when developing prices for advice and guidance, IVF and smoking cessation. Many local areas have developed advice and guidance services, and these should be supported, rather than restricted, by the introduction of nationally determined prices.

g. Evidence-based interventions

We support using the tariff as an implementation lever to ensure category 1 'do not do' interventions are no longer routinely provided, as our members supported this policy being mandated.

2. For more information

If you would like any further detail on our response please do not hesitate to contact our Head of Policy and Delivery, Sara Bainbridge at s.bainbridge@nhsc.org, or Member Network and Policy Manager, Thomas Marsh at t.marsh@nhsc.org.