2016/17 National Tariff Payment System: statutory consultation response

NHS Providers is the membership organisation and trade association for the NHS acute, ambulance, community and mental health services that treat patients and service users in the NHS. We have over 220 members – more than 94% of all NHS foundation trusts and aspirant trusts – who collectively account for £65 billion of annual expenditure and employ more than 928,000 staff.

KEY MESSAGES

NHS Providers recognises that many of the proposed changes for the 2016/17 tariff are welcome for the sector, in particular the net price uplift. However, it needs to be recognised that when looking at the proposed tariff package as a whole and the numerous cost pressures that providers face, this tariff represents a holding position for providers rather than genuine new investment in capacity. Cost inflation increases are largely attributable to offsetting growing pension costs, mandated staff pay rises and higher CNST charges. This combined with a more realistic, but still stretching efficiency factor, means that providers are still being asked to provide more and higher quality care within a limited financial envelope. Therefore NHS Providers has the following views on the tariff proposals:

1. **Strongly supports the reduction of the efficiency factor to 2 per cent**, having argued for a reduction of the efficiency factor in previous consultation responses on the tariff. We note however that the statutory consultation notice suggests that an efficiency factor of 1.5% would be consistent with the price setting bodies’ own estimates of previously achieved efficiency in the sector. Therefore, we would like to highlight that 2 per cent will still be a challenge for the sector, and will require sustained effort at local level to realise.

2. **Considers that the emergency marginal rate and 30 day admissions business rules are outdated and no longer appropriate.** NHS Providers supports the lowering of the marginal rate for emergency admissions however, for both this and penalties for readmissions we still:
   - Fundamentally disagree with the principles behind the rules.
   - Assert they are out of sync with other financial incentives introduced into the system for 2016/17 which are intended to stabilise finances. The application of these rules will still take substantial investment away from the frontline.

3. **Asks for clearer guidance to help local contract negotiations.** The headline net uplift in prices in the consultation is quoted at +1.8 per cent, including a 0.7 per cent rise in CNST prices across sub chapters. However in previous years the headline uplift has not included any rise in CNST prices in its final figure. This change in definition has already opened up ambiguity in local price negotiations – clear guidance is needed for providers and commissioners to enable constructive contracting discussions. All providers are affected by CNST premium increases, irrespective of whether they have locally or nationally priced services and therefore we believe that 1.8 per cent should be the starting point for the discussions.

4. **Accepts the rationale for the postponement of HRG4+.** Although considerable effort and engagement was committed to by the arms length bodies, commissioners and providers in order to implement HRG4+ for 2016/17, NHS Providers accepts that financial stability is key for this coming financial year and it is right to postpone volatile changes. We hope efforts are made to introduce HRG4+ in 2017/18, alongside actions that reduce any resultant financial instability in those providers most affected by the move to a new currency design.

5. ** Welcomes the progress made on mental health payment models.** NHS Providers has consistently argued payment reform is long overdue for the non-acute sector and we welcome recent publications from NHS England and Monitor outlining new payment approaches and currencies for mental health providers, looking to help them move towards capitated and episodic payment models in 2017/18. There is still more support needed here to help providers be ready to move to these models in 2017/18 as well as further work to improve community currency design.
We underline in greater detail our thinking behind each of these 5 key points in the next section of the document, as well as our comments on other areas of relevance for this year’s tariff consultation.

1. THE EFFICIENCY FACTOR AND PRICES

The figures for quarter three for 2015/16 show that 75% of the provider sector is in deficit, with a net total deficit of £2.26bn. Over the last parliament, a 4 per cent annual efficiency requirement has helped create unsustainable pressure on provider finances which has substantially contributed towards the continually worsening deficit. It is welcome to see in the consultation document that the efficiency factor of previous years has been considered in reaching this year’s lower figure.

However the consultation outlines, through several different sources, that evidence supports a range of 1.2 per cent to 2.5 per cent for the efficiency factor in any given year. It also notes that an efficiency factor of 1.5 per cent was considered for this financial year. Therefore, we would like to highlight that 2 per cent will still be a challenge for the sector, and will require sustained effort at local level to realise.

In the consultation document, it is stated that the price setting bodies could only calculate draft relative prices for its summer engagement with the sector as they were awaiting the outcome of the government spending review. Draft prices were then not published until December, creating substantial uncertainty in the sector about the pricing framework for 2016/17. This lack of communication with the sector did not support or facilitate financial planning at the local level. Furthermore, we continue to reassert, as the Health and Social Care Act 2012 intended, that price setting should be independent from national budget setting. The consultation document itself notes that the key principle for setting price levels is to “[ensure] that a reasonably efficient provider can recover their costs after adjusting for any additional incentives”. How providers are compensated therefore should be based on these factors only - linking the prices to wider national policy decisions undermines the key principles of independent price setting.

For estimating the inflation cost uplift, NHS Providers is encouraged to see the price setting bodies are considering using publicly available labour cost inflation forecasts from the Office of Budget Responsibility (OBR) when deciding on cost uplift for labour costs rather than Department of Health estimates. We have asked for more independent bodies’ research to input into the setting of cost uplift levels and the use of independent data sets should improve the transparency of price setting analysis. We hope to see this approach adopted for the 2017/18 tariff.

To further improve cost uplifts analysis, NHS Providers would also like to see publication of a separate annex covering in detail how inflation cost uplifts are calculated, in a similar manner to annexes for other factors such as market forces factor calculation. Several aspects of the cost inflation section state it has taken into account various cost factors affecting providers, but our members would like demonstrable evidence this is the case. For example the consultation states the inflation uplift fully accounts for the increases in National Insurance pension contributions providers will have to bear in 2016/17 - approximately £1bn of additional costs. Of the 2.4 per cent pay drift inflation increase, 1.8 per cent is allocated against covering increased pension costs. However, no further evidence is offered as to whether this genuinely covers all, part or some of the calculated increase in pension contributions.

Similarly, ensuring that staff pays awards and any changes to contracts leading to an increase to the pay bill are fully incorporated in to the inflation cost uplift is essential. For example, NHS Providers is concerned that the changes to the junior doctors’ contract mean it may no longer be cost neutral. This would mean it results in an additional cost pressure unless it is provided for in the tariff. Therefore analysis showing what the price setting bodies predict to be the total increased costs within areas of pay inflation, and how that explicitly relates to the percentage uplift figures for inflation would be welcome.
2. BUSINESS RULES

NHS Providers welcomes the increase of the marginal rate for emergency services to 70%, in line with the rate ETO providers used in 2015/16. However, NHS Providers would still question the use of the marginal rate as an incentive to drive behaviours. It has a poor track record in meeting policy objectives and the evidence base to support its use is weak - the ever increasing number of admissions through A&E is a clear indicator that this is the case.

There were 475,500 emergency admissions in the last twelve months, up 2 per cent on the preceding twelve-month period. This has outpaced the growth in A&E attendances, suggesting patients arriving at A&E have increasingly more complex care needs.

There is limited evidence to suggest that provider behaviour is responsible for this increase. For example, demographic influences such as a growing and ageing population are far more likely to be strong contributory factors and are completely out of the control of individual providers. When providers alone have little control over front door activity, but are penalised financially for increases in demand, any potential ‘incentive’ aspect is lost, making the marginal rate system fundamentally flawed.

Similarly, using 2008/9 attendance data as baselines for the marginal rate is in urgent need of updating to a more recent reference year to reflect increased demand on A&E services over recent years. Similarly data used for Monitor’s and NHS England’s 2013 review of the marginal rate’s effectiveness is now also out of date.

Additionally, the marginal rate is out of sync with the national direction of policy. The calculation for the allocation of sustainability funds for 2016/17 to providers was based to a large extent on the volume of A&E care they provide – a clear indication that the system acknowledges this type of care is proving to be a key factor in providers’ lacking financial sustainability. It is perverse therefore to be allocating funds to providers on a basis that recognises the heavy costs burden of this type of care, while also using the national payment system to penalise providers financially for those very same services.

Fundamentally 2016/17 needs to deliver a financial package that returns the sector back to balance, with maximum stability afforded to provider budgets. Continuing to penalise providers heavily through the marginal rate is therefore not appropriate and counterintuitive to delivering this key priority.

We welcome that the marginal rate for specialised services has been for removed for 2016/17, and would advocate the same is now done for emergency services. If this is not possible, at the very least there needs to be greater transparency on how the retained money is spent by commissioners to address the increase in A&E demand – this is particularly pressing as winter resilience funding is now allocated as a core part of commissioner allocations.

For similar reasons, NHS Providers would argue for the removal of the 30-day readmission national rule. It again penalises providers for issues that are often out their direct control, such as reductions in social care provision. Additionally, the central bodies estimate the total cost burden of this rule on providers is around £200m for 2015/16, and therefore has substantially contributed to levels of deficit across the sector. Removing this rule would significantly aid the sector in returning to financial stability, which the consultation document itself recognises is the key task for 2016/17, and would be in line with amendments to other national rules such as the suspension of sanctions against core access standards.

3. GREATER GUIDANCE AND CLARITY

NHS providers and their commissioners are already engaged in negotiations over local prices. As stated the headline net uplift in prices in the consultation is +1.8 per cent, including a 0.7 per cent rise in CNST across sub chapters. However in previous years the headline uplift has not included any rise in CNST prices in its final figure.

The consultation document highlights:
“Where prices are determined locally, it is the responsibility of commissioners to negotiate and agree prices having regard to relevant factors, including opportunities for efficiency and the actual costs incurred by their providers” and a requirement for “commissioners and providers to have regard to national price adjustments [our underline]. In effect they should be used as a benchmark to inform local negotiations.”

Since CNST is explicitly now in the headline price adjustment, we believe that 1.8 per cent is a legitimate starting point as the benchmark for local negotiations on prices. If this is indeed the case further guidance should make this explicit to support discussions for 2016/17 contracts.

Similarly our mental health members need guidance as to how parity of esteem funding should be represented in contract offers from commissioners. Some commissioners are not offering investment in line with their increased allocations for mental health parity of esteem funding, arguing that these increases need to be offset by the benchmarked national tariff price rates adjustments and their impact on local prices. Again NHS Providers would argue that the increase in allocations for commissioners for parity of esteem should be viewed separately and be delivered above any increases coming from locally negotiated prices based on national benchmarks, and this should be reflected in additional guidance for the sector.

4. HRG4+ AND CURRENCY DESIGN

NHS Providers agrees with the principle outlined in the consultation document that there is a clear need for stability this year. This has an impact on choosing whether to implement a new currency design, and we agree with the proposed postponement of HRG4+ until 2017/18, and that using ETO currencies is a sensible way to maintain stability. We agree also with the removal of the new best practice tariffs that relied on the introduction of HRG4+ and the more limited changes to the high cost drugs and devices lists.

NHS Providers would still like to see a move HRG4+ in the future, and it is clear from the summer engagement that the majority of the sector is in favour of the move. We would strongly support the price setting bodies in progressing to a stage where HRG4+ can be implemented in 2017/18.

However it is important that the instability HRG4+ would introduce is mitigated. It is to be expected that introduction of a new currencies would introduce some price relativity variation but the price setting bodies must be able to demonstrate they understand what is driving that variation in certain currencies in order to effectively support providers in the implementation of the new tariff. We believe it is important to clarify, where there are significant percentage changes for service lines, whether the change is a result of cost data being excluded, significant changes in activity levels, deliberate policy, or step changes in reference costs in these specialties. This is particularly the case for specialist providers, where the proposed changes made by HRG4+ did not result in the expected impact i.e. an increase in funding through the base price for specialised services, with some quite marked negative changes in the base tariff of certain service lines.

These issues must be addressed in order to ensure that a repeat of a postponed introduction of HRG4+ for 2016/17 does not happen in 2017/18. NHS Providers is prepared to offer its support and engagement with its membership to input on currency changes to ensure that is not the case.

5. MENTAL HEALTH AND NON ACUTE PAYMENT SYSTEMS

Historically there has been an over reliance on acute, rather than non-acute, data to set national tariff rules, such as the efficiency factor. Cost uplift factors do not take in to account the specific characteristics of these sectors, such as the higher proportional spend on staffing. Although we acknowledge that providers and commissioners are free to agree different efficiency factors and price uplifts should they wish when negotiating local contracts, having payment systems that more accurately reflect the costs for these providers has been something we have long campaigned for.
NHS Providers therefore welcomes the draft payment models and advice that Monitor and NHS England has produced as well as the engagement work NHS England carried out in assessing the ability of providers and commissioners delivering capitated and episodic payment models. We agree with the conclusions in the consultation document that the sector is not ready to move to these models in 2016/17, and that action instead should be taken by both providers and commissioners to ensure they are ready to implement them in 2017/18. However, there is a need for central support to ensure that happens. Starting the necessary collection, reporting and integration of accurate mental health care data, as well as developing robust quality and outcome measurements will require additional resources and investment from providers. It will also require support from national bodies to ensure that the burden of preparing for these new contracting models does not impinge the delivery of high quality care.

OTHER POINTS ON PROPOSED CHANGES FOR THE 2016/17 TARIFF

Top up payments for specialised services and specialised services risk share

NHS Providers agrees that most of the changes to top ups for specialised services were heavily reliant on HRG4+ and agree with the postponement of those changes. However, related to points made earlier in this response, if these changes to top ups for specialised services are introduced with HRG4+ in 2017/18, it is vital to ensure they do not create financial instability for certain providers groups. In particular, member feedback indicates that providers with large volumes of specialised orthopaedic and children’s services would have been significantly disadvantaged under the previously proposed top ups. It is important that these members’ views are fully taken into account for 2017/18 and that the top ups are adjusted accordingly.

Similarly, NHS Providers strongly welcomes the removal of the specialised services risk share in 2016/17. However, we note that significant concerns were raised during engagement with the sector about proposed levels of risk share planning to be introduced in 2016/17 and the modelling work that underpinned it. NHS Providers would therefore strongly advise against any reintroduction of a specialised services risk share alongside any introduction of HRG4+.

Change to the submission date for local variations

NHS Providers agrees with the principle that local variations should be submitted in good time and therefore agree in theory with a deadline of 30 June 2016. However, we believe there should be flexibility over this date depending on circumstances that providers and commissioners are placed in by systemic issues. The consultation document indicates:

“We do not think that setting a deadline for submitting local variations to monitor will force providers and commissioners into inappropriate contracts, as providers and commissioners are already expected to have contracts in place by the beginning of the financial year.”

However, this statement does not reflect reality on the ground. The draft standard contract was not released until March, with the final contract only expected to be confirmed days beyond the start of the financial year. Additionally full CQUINs were only confirmed on 9 March and these had significant changes contained within them. It is unrealistic therefore to expect contracts be signed before the start of the financial year when key documents and information have not been released in a timely manner to the sector. This being the case, having a variation deadline that is inflexible is likely to make inappropriate contracts more probable. Artificial dates that put undue pressure on local negotiations are not what are required for system stability. NHS Providers recommends therefore that if provider and commissioners are struggling to have contracts signed before the start of the year due to no fault of their own they are not unfairly penalised.

Local modification applications and changes to the method for local modifications to reflect additional funding
NHS Providers believe that more detail is needed to see what ‘taking into account’ of additional STF funding means when Monitor considers a local modification. We do not believe that providers that have received STF funding should suffer unfair bias or penalisation when their applications are considered, as local modifications may or may not be needed separate to STF funding.

There are a number of issues with regard to the proposed changes to the local modification process:

- **30 September deadline:** We understand the need for commissioners and providers to adjust plans and budgets as far in advance as possible but would welcome clarity on how the proposed new deadline is compatible with the necessary evidence and information providers are required to put together for the application as outlined in the current guidance. For some services, providers will only know if they need to apply for a modification once they are aware of the impact of prices in the next financial year. However, the prices for the next financial year are routinely published after 30 September in the previous year. This means that under the proposed change, if providers were to wait until the formal publication of the final prices in the statutory consultation notice, it would be too late to apply for a local modification. This would mean that the provider is then left in a situation that means they have to deliver an uneconomic service for an entire financial year, only applying for the modification for following September.

- **We would suggest that instead of setting an arbitrary fixed deadline for the application of a local modification, that it is instead set to reflect the tariff engagement and setting process for that financial year, given that Monitor and NHS England have published the statutory consultation at different times over the past three financial years, so that providers have the appropriate time and information necessary to put an application together.**

- **We would also raise a concern about the lack of transparency over the practical local health economy implications of a successful local modification application.** When a successful application is made and more funding is required to support services, we understand the expectation is that the higher prices would be met through existing CCG allocations. The issue here is this makes a successful application ‘zero sum’ for the local health economy as a whole - if one provider is supported in this way, other providers in the same health economy may therefore receive less as a result since it will require the CCG to relocate existing resources. This is counterintuitive when these providers may already be trying to work closer together across the whole health economy to find solutions to ease the pressures – for example in success regime areas – that might be causing the uneconomic service delivery in the first instance. We would therefore recommend that modifications are not paid for through existing CCG allocations but through additional funding made available centrally.

- **We have received feedback that the modifications application procedure is a burdensome process for individual trusts.** As the guidance on modifications states the process for local modifications requires providers and commissioners to engage constructively with each other to review the current model of service provision, consider alternatives, and decide on a delivery model that is in the best interests of patients before an application is even made. This complex process can necessarily take an extended period of time. We would recommend that Monitor takes steps to make the application procedure as streamlined as possible so that trusts who have uneconomic services do not feel inhibited about making applications due to the complexity of the process.

**Amending local pricing rule 7 to support the central procurement of high cost devices**

- **To note, we support a central procurement function for high cost devices, but some clarification is required over what will happen to providers with existing procurement contracts which do not lapse on 31 March 2016.**
BROADER POINTS

Objection mechanism – NHS Providers has been clear that we did not support the changes to the objection mechanism:

- The objection mechanism was triggered for 2015-16 tariff which showed initial proposals were undeliverable.
- However under the new rules for the mechanism, NHS trusts or foundation trusts make up 62% of ‘relevant providers’ able to object, so even if every relevant NHS provider objected to the proposals, the threshold would not be met.
- Also by abolishing the “by share of supply” trigger it is more difficult for providers delivering care at the frontline to make their voice heard if they object to the tariff methodology.

Multi year tariffs - with multi-year funding allocations awarded to NHS England and commissioners, NHS Providers would like to see progress towards the implementation of multi year tariffs to introduce greater stability into the provider sector and aid local health economy and system wide planning.

Document publication - there is still a pressing need to ensure more joined up and early publication of other key documents that complement the tariff such as the standard contract and CQUIN guidance. This is necessary to avoid providers and commissioners being continually pressed into difficult and time constricted contract negotiations year after year. With adequate planning, this situation should be avoidable.

ENGAGEMENT

- NHS Providers welcomes the more collaborative approach that Monitor took to sourcing providers to implement thee impact assessment, and note their responses to the feedback on the impact assessment final report, which is significantly improved from the previous year.
- However, with the impact assessment and other pieces of in year work there is still a need for clear, regular but simple messaging that goes out to the provider sector. For example there were considerable periods without communication last year where new proposals were being developed but were not communicated with the sector until their formal announcement. This communication can be as simple as letting the sector know of the work the price setting bodies are doing throughout the year via bulletins, outlining how providers can get involved if desirable and sharing any high level early outputs that are publishable.
- Additionally, there were a huge amount of engagement workshops on price setting last year which were a welcome move. However, feedback from members has indicated timing was seen as difficult to enable a full range of feedback, as they took place before the necessary range of price information was available (for example the efficiency factor and cost inflation uplift). Wide scale workshops of a similar scope in future therefore should be timed to allow providers to input on all areas of price setting if possible.
- With removal of HRG4+, this also ultimately meant these workshops had little impact on 2016/17 prices, but lessons and feedback from providers should not be lost for next year if HRG4+ is introduced for 2017/18.