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Payment system reform proposals for 2019/20: NHS Providers response

NHS Providers is the membership organisation and trade association for the NHS hospital, mental health, community and ambulance services that treat patients and service users in the NHS. We help those NHS foundation trusts and trusts to deliver high-quality, patient-focused care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate. NHS Providers has all trusts in membership, collectively accounting for £84bn of annual expenditure and employing more than one million staff.

Key points

- We welcome the ambitions underpinning this consultation, to support providers and commissioners to work more collaboratively and to develop a more streamlined, and aligned system of payments and incentives for both commissioners and providers. We would also like to take this opportunity to note that NHS Improvement and NHS England have led by example in working jointly to produce the proposals.
- We welcome the intention to address challenges within the current national tariff payment system and develop a model that shares incentives to reduce avoidable A&E attendances, and more fairly reflect the costs incurred by trusts. We appreciate that these proposals are set within a broader context of change alongside the development of a new financial framework and the NHS long term plan. We therefore support the reasonable and pragmatic decision to set a one-year tariff for 2019/20.
- In addition to the aims set out in the document, we believe any new payment system should seek to: relieve pressure on emergency departments; align incentives for providers of acute, community, primary care, social care and mental health services; share risk between providers and commissioners; and correct the historic under funding of emergency services, to restore the financial health of the provider sector as a whole.
- The payment system for emergency care is in need of reform given the impact it has on acute provider deficits, and we welcome the intention to address this. We also welcome the abolition of the marginal rate emergency tariff, which we have called for, for many years, as well as the removal of existing contractual penalties for readmissions. However there is a risk that the proposals set out within the consultation recreate problematic aspects of the existing model.
- A blended payment approach for mental health and community services would represent a significant change for both sectors. We recognise that the development of this model for these sectors is still in the early stages and therefore look forward to further engagement on this as the detail is developed.

- Changes to outpatient payments threaten to reduce funding significantly while leaving providers with limited flexibility to reduce their costs, due to fixed overheads and the limited availability of non-consultant staff.
- Changes to the market forces factor are long overdue but NHS Improvement must take them into account as it sets control totals and assesses trusts' financial performance. NHS Improvement and NHS England must ensure their approaches to pricing and CCG allocations are as consistent as possible.
- We suggest the centralised procurement service is made available to trusts that are willing to fund it, via a mark-up on prices. We have concerns that the proposal to top-slice the tariff to fund centralised procurement will unfairly load financial risk for a new model onto all trusts.
- Many of the proposals are outlined in general terms within the document. We look forward to more detail on these proposals and how they will support the longer term strategic aims for the service when the statutory consultation is published.

Introduction

We welcome the opportunity to engage on the outline proposals for the 2019/20 tariff, and note the number of occasions in recent months where providers' views have been sought. Unlike the last round of engagement, which was for a two year tariff, this year's proposal covers a single financial year. We support this reasonable and pragmatic approach, given the need to finalise 2019/20 proposals in a timely manner, and to coordinate the focus of the new financial framework with the aspirations of the forthcoming NHS long term plan. We would also like to take this opportunity to note that NHS Improvement and NHS England have led by example in working jointly to produce these proposals. We look forward to further opportunities to engage with them as they develop the proposals.

We welcome the national bodies' intentions to address challenges within the current national tariff payment system and to develop a payment model that shares incentives across providers and commissioners to reduce avoidable A&E attendances; and more fairly reflect the costs incurred by trusts.

However many of the proposals are only outlined in general terms at this stage and it is difficult to predict with certainty from the information provided what their impact will be on providers. We also note that some of the measures – particularly changes to payments for emergency care – represent a significant shift from the past and it would be helpful to know whether they are designed for the long term or just for one year. We appreciate that some of this detail may not be available until the NHS long term plan is published. We therefore look forward to commenting in further detail on the statutory consultation on the tariff.

Blended payment approach for emergency care

The payment system for emergency care is undoubtedly in need of reform, as it is one of the main drivers of acute sector deficits. However, following extensive engagement with provider trusts, we do have some concerns with the blended payment system proposed.

In addition to the aims set out at the beginning of the consultation document we would also want to see a reformed payment system for urgent and emergency care:

- relieve pressure on emergency departments;
- align incentives for providers of acute, community, primary care, social care and mental health services;
- share risk between providers and commissioners; and
- correct the historic under funding of emergency services, to restore the financial health of the provider sector as a whole.

However, we are concerned that the current proposals risk leaving providers and commissioners with competing incentives at the planning stage, load risk onto providers, and consequently may make contractual disputes more likely.

Trusts are concerned that adopting a completely new framework for funding urgent and emergency care for a single year would be extremely disruptive, and this would be unhelpful if it were not part of a longer term programme of reform.

These points are explored in more detail below.

Impact on provider financial position

Whether the blended approach helps reverse financial deterioration in the acute sector depends in large part on the overall resource available. Since these proposals were first shared there have been indications that as much as £1bn may be taken out of the provider sustainability fund (PSF) and re-routed into emergency care. Putting that money into mainstream funding would relieve financial pressure among acute trusts – but we would need to be assured that mental health and community trusts also stood to benefit from shrinking the PSF, which has been available to all sectors since it was introduced.

Given the indications that the price paid for activity within planned levels would be set nationally, many trusts may find that even within plan, their costs are not fully covered.

The blended approach could offer an improvement on the existing situation, if extra funding is available to cover the cost to trusts of providing emergency care, if providers are genuinely funded to cover 100% of the costs they incur from admissions, and if local system plans are set locally and are allowed to realistically forecast activity. However under the rules proposed, activity planning will become increasingly important.

Trust feedback suggest that while those systems with strong relationships may benefit, in the majority of systems where relationships are still developing the new approach may make transactional behaviours worse – particularly if a realistic activity forecast was not affordable to commissioners. It is therefore possible to imagine protracted arguments between providers and commissioners, which could make the process of agreeing contracts more drawn out and resource intensive in some areas. A national "default"

position, to be used in areas that cannot agree a way forward, would need to be clearly articulated and the baseline would need to be regularly updated to mitigate the risk of the MRET model being recreated.

Marginal Rate Emergency Tariff

We have consistently raised concerns about the use of the marginal rate emergency tariff (MRET). We welcome the intention to abolish it, along with the penalties for readmissions within 30 days. MRET has not been credible for some years and has been a major contributing factor to endemic deficits in the acute sector by penalising trusts for additional activity that they have little control over. However it should be acknowledged that moving away from this framework will carry some risk. Crucially, more detail will be needed on what "financially neutral" means for providers in the context of the abolition of MRET, as while the marginal rate is commonly used in some regions, it is barely applied in others. As the MRET is removed, there is a danger that, without extra money to pay for emergency care overall, uplifting the payments to providers that have had funding withheld in the recent past will leave less for trusts in areas which have already voluntarily stopped using MRET. The proposals contain no mention of the requirement on commissioners, under MRET, to invest in measures that reduce emergency demand. This requirement should remain once MRET is abolished.

Variable element of the blended approach

The proposal to set the variable element of the blended payment approach for emergency care to 20% of the HRG price for the first year would load the risk of overperformance onto trusts. This is concerning given steadily increasing demand for urgent and emergency care services. We are also concerned that this could unintentionally replicate the more negative effects of the MRET, causing deficits in acute trusts which are subject to high rates of admissions growth. As colleagues in NHS Improvement and NHS England are aware, admissions via A&E are a system wide responsibility.

The proposals could therefore go further to improve on the current lack of alignment of incentives between all providers and commissioners in a local system. As is currently the case, those that can do most to help improve performance and contain emergency care costs – particularly primary care and social care providers – still have no financial stake in doing so. The 20% rate also potentially creates a perverse incentive for commissioners not to invest in keeping people out of hospital. If a workable admissions avoidance scheme, for example using GP or mental health services, was likely to cost more per patient than 20% of an admission via A&E, a commissioner would save money by not setting it up and paying the lower rate for the patient to go into hospital. Under those circumstances, it would be difficult for a commissioner to construct a business case demonstrating the admission avoidance scheme offered best value for money.

The 20% rate would not adequately compensate trusts for the cost of an admission because it does not take into account the high marginal costs of unplanned accident and emergency activity. For example, when activity exceeds planned levels, a hospital may have to open extra capacity, which would increase its fixed costs. In cases such as this where "stepped" costs are incurred, the 20% rate is likely to severely underfund trusts. The new marginal rate does not take into account the knock-on effects of unplanned

emergency activity on general hospital capacity – as a greater number than expected of inpatient beds are filled with emergency patients, there will be less capacity for trusts to provide elective care, and thereby generate income. Finally, as is the case under the current system, the proposals fail to take into account the opportunity costs to providers of rising demand for emergency services.

Ambulatory care

While it is generally accepted that the increase in ambulatory care seen in recent years has been beneficial both to patients and to local systems, it is not clear how this would be supported by the proposed blended payment system. The aim of the blended payment system appears to be to contain growth in A&E activity within a planned level. However it does not incentivise a switch towards a more efficient ambulatory model of A&E, where appropriate. The lack of consistent coding or pricing for ambulatory care may be one reason why the potential advantages of the model are not properly understood nationally, and may be a barrier to more widespread adoption. The detail underpinning these proposals will need to address this.

The "break glass" threshold

The proposed "break glass" threshold is well intentioned and could limit the liability for trusts and commissioners, and give providers and commissioners an incentive to agree a realistic plan from the outset. However, as with the 20% rate, it gives providers and commissioners opposite incentives, rather than unified ones – where activity is rising beyond plan, the provider will be motivated to renegotiate, while the commissioner will save money if it does not. It is therefore easy to see how this feature could become the subject of further disputes between providers and commissioners in pressurised or distressed systems. This would cost both time and money. It will also become more difficult for providers to plan for income if contracts could potentially be renegotiated in-year.

Design options

The proposals include two options for how the blended payment system could work in practice. While the two are arithmetically equal, we have heard mixed responses from trusts about their preference between them. Some say Option A is preferable, as it provides greater certainty over the phasing of income for the planned level of activity, and will also support cash positions, while others believe there would be no difference between the two.

Blended payments for community and mental health

The blended models proposed for mental health and community services would represent a significant change for both sectors, and therefore more detail is needed on how this approach would be implemented. We are concerned that there is not enough time to develop detailed, workable policies that can be implemented at the beginning of 2019/20. Significantly more detail and clarity is needed on all aspects of these proposals, particularly on the unit of activity that the variable element would be applied to. We would also welcome more detail about the aims of introducing blended payment systems in these sectors to support the overall strategic direction of the sector. If the approach taken in the acute sector

was replicated for community and mental health, the impact would be to give providers an incentive to contain growth in activity, which may not be desirable in the community and mental health sector as we look to shift care closer to people's home and avoid admissions to hospital.

Finally, we believe there is a need to align incentives between providers of acute, community, mental health and primary and social care. There is a risk that developing discreet blended payment systems for each would fail to support integration across sectors.

Outpatient attendances

We have concerns over the use of the payment system to incentivise change at a local level, in order to curb costs. Trusts will always look to adopt more cost efficient ways of providing outpatient services. The question is not whether there are efficiencies and improvements available, but whether holding down prices at a national level is the best way to realise them, as explored recently by the Nuffield Trust.

The current proposals threaten to reduce funding of outpatient services significantly while leaving providers with limited flexibility to reduce their costs. As they currently stand, these proposals are likely to introduce more cost pressures for the provider sector.

Proposed prices for non-face-to-face follow ups

Trusts tell us that a non-face-to-face appointment will not necessarily be less time consuming than a face-to-face appointment, and will therefore not increase outpatient capacity for the provider. Trusts are concerned that if the purpose of this policy is to reduce the cost of consultant time, it will have a limited impact.

There are also fixed costs and overheads involved in the delivery of outpatient services, beyond the cost of the consultant. Even if more services are provided in the community or remotely, trusts may not be able to take fixed costs out immediately. A lead time should therefore be built into any savings assumed.

Proposed prices for non-consultant led attendances

Trusts have raised a number of challenges with the proposals which are outlined below:

- There may be limited capacity in the workforce needed to enable more outpatient work to be carried out by non-consultants. For example, there may not be enough nurse consultants or consultant physiotherapists available to provide more outpatient appointments using a different workforce mix.
- Encouraging a shift towards a non-consultant led service does not take into account the times when it would be more appropriate for the attendance to be consultant led. This may lead to more follow up appointments in the long run.
- Some of the prices proposed in the draft price relativities workbook are lower than many local prices that providers and commissioners have negotiated.

- While the non-mandatory prices may offer some welcome flexibility, there needs to be recognition that, due to delays in the publication of prices, providers and commissioners may struggle to negotiate prices within the current timeframes.

The single price pilot

Trusts tell us that applying a single price for a specialty may be too broad an approach, as outpatient care covers a wide range of activities, even within specialties, and it is not appropriate to apply uniform prices to enforce blanket changes. For example, patients with long term complex needs often require increased face to face follow up attendances. There will be trusts whose patient cohorts include a high proportion of patients with long term conditions, who would lose out significantly under the pilot.

Market forces factor

We accept that changes to the market forces factor (MFF) are long overdue, and taking a phased approach is very welcome given the potential change in income and allocations for several providers and commissioners. There will inevitably be winners and losers from these changes. It is important that where trusts' financial positions become more challenging as a result of these changes, NHS Improvement takes this into account when setting financial control totals and regulating trusts under the single oversight framework.

It is now necessary to have more clarity on whether locally agreed prices will also need to be renegotiated in the light of the changes to MFF. Local systems will need to know whether the MFF changes will affect CCG allocations. If MFF is applied to local prices, this could lead to a much greater impact on individual providers than just applying the changes to national prices. There must also be money available to commissioners to meet any increase in the amounts payable to providers – ideally, the approaches taken to prices and CCG allocations should be as consistent as possible.

Centralised procurement

Providers have serious concerns about the Department of Health and Social Care's intention to fund Supply Chain Coordination Limited (SCCL) from money allocated to the national tariff.

- This proposal loads all the financial risk for the new centralised model of procurement onto the provider sector. Funding SCCL via a top-slice of the tariff will leave trusts with an unfunded cost pressure if centralisation does not yield sufficient savings to cover its increased running costs. Problematically, full costs would be incurred from 2019/20, although benefits may not be realised immediately.
- Trusts that do not use SCCL, or which have limited opportunity to use it, tell us that they are concerned about having their income effectively reduced to pay for a service they will not use. This is particularly relevant to trusts whose business does not require the use of high volumes of consumables such as mental health or community trusts. While the publication suggests adjustments for different sectors for this reason, many providers run services in more than one sector, so this will be difficult to implement. It

is not clear how or whether a trust which provides only acute services will be charged differently to one that provides acute and community, when their procurement costs will naturally be different.

- It is currently unclear whether a central purchaser will always be able to make the prices that are currently achieved by the best available to all. Much procurement is already undertaken at scale through regional hubs. The change that is proposed is therefore dependent not on a move away from single-trust purchasing, but on a shift of from regional to national procurement. However it is not currently clear that this will save money of the order required to offset the reduction in payments to providers. We suggest the centralised service be made available to trusts that are willing to fund it, and that SCCL's running costs are funded via a mark-up on prices.

Maternity pathway

The decision to introduce non mandatory prices is inconsistent with the well established approach to national tariff-setting, which encourages providers to focus on quality within a common financial envelope. Trusts have given mixed feedback on whether non mandatory prices are an appropriate response to the problems presented by the inclusion of public health services in some integrated packages. However, they agree that it will likely lead to increased administration costs and increases the risk of contractual disputes with commissioners which cost time and money.

We welcome the proposal to move the direct commissioning of specialist fetal medicine to NHS England. Such highly specialised diagnostics and interventions are undertaken by a small number of providers and we understand these have not been inadequately compensated for those services since specialist fetal medicine has been part of national prices.

Feedback from trusts indicates overall support for reforming the payment mechanism for complex births, as the current system fails to adequately reflect complexity and leads to over and under reimbursement for providers. However it may lead to new cost pressures for trusts with smaller maternity units that deal with a greater proportion of births with no complications, assuming prices are lower for less complex births.

Next steps

We understand that the 2019/20 tariff proposals are being developed alongside the new financial framework and in the context of the NHS long term plan. We have welcomed regular and helpful engagement with NHS Improvement as they have developed these proposals. While we understand the constraints on the timing, and the need to be pragmatic to ensure the tariff aligns with wider ambitions to be set out in the long term plan and associated planning guidance, we are conscious that it will be important for the statutory consultation and final 2019/20 tariff to be published as soon as possible in order for trusts and commissioners to plan and agree contracts in time for the beginning of the financial year.

We look forward to working with NHS Improvement and NHS England as the detail underpinning these proposals and the overall new financial framework for the NHS is developed.