

NHS Providers' response to the 2020/21 national tariff payment system consultation

Following the tariff engagement document published by NHS England and NHS Improvement (NHSE/I) in November, the provider sector was asked for its views on the 2020/21 national tariff payment system. NHS Providers' summary of NHSE/I's proposals can be found [here](#). Please find below our response to the statutory consultation notice.

Blended payment for outpatient attendances

1 To what extent do you support this proposal? *Neither support or oppose*

There has been a mixed response from the provider sector about the potential effectiveness of blended payments for outpatient attendances.

The blended payments guidance document illustrates how prices are determined for planned activity, and providers and commissioners may in theory be able to estimate activity levels. The document states this will be based on the previous year's activity levels, and then adapted given demographic changes, health needs and historic trends. However, there is a danger that given the inherent complexity of these factors, some agreements between trusts and commissioners may fail to accurately anticipate actual demand.

Depending on the maturity of sustainability and transformation partnerships (STPs) and integrated care systems (ICSs), some systems will find it easier than others to predict referral rates. Given that the fixed element will account for the largest proportion of blended payments for outpatient attendances, it is important that clear agreement is reached over expected activity volumes, and that contractual disputes between providers and commissioners are limited.

The variety of risk-sharing options, including activity-based risk share arrangements or adjustments based on the level of GP referrals, are sensible proposals to mitigate unanticipated activity levels, and should be more explicitly encouraged in the guidance. If local agreements underestimate actual activity levels, and there is no risk sharing agreement in place, providers may be unfairly penalised for cost or performance issues caused by unanticipated demand outside of their control. Without risk sharing agreements in place, providers may be reluctant to withdraw from current payment by results (PbR) or block arrangements.

Trusts are also concerned about the process for agreeing activity levels with specialised commissioners. For providers specialising in treating cancer patients, for example, it will be difficult to reduce face-to-face outpatient attendances to the same extent as other providers delivering non-specialised services. Specialist providers of cancer services will deliver a much a higher volume of cancer care activity than district general hospitals, and the on-treatment pathway for cancer care will be less amenable to the reduction of face-to-face appointments than the off-treatment pathway. Clinicians are concerned by the prospect of conducting more discussions about diagnoses, prognoses, and the complexity of treatment to cancer patients via phone calls.

It will also be complex to anticipate activity levels for the fixed element, and there may be protracted contractual negotiations with commissioners from outside of a provider's system. Moreover, the standard contract states that NHS England/Improvement (NHSE/I) regional teams will play a direct role in the resolution process should providers and commissioners enter a contractual dispute. It therefore appears to be difficult for the regional team to act as neutral arbiter, given that NHS England also commissions specialised services.

We welcome the recognition in the blended payments guidance document that the move to locally developed quality- or outcomes-based approaches is unlikely to occur during the first year of implementation. It is important that trusts are given autonomy in developing outcomes-based measures with commissioners to take into account the health needs of their local populations. More case studies should be provided, so that trusts are given a clearer idea about how to construct the risk share and outcomes-based elements with commissioners. Guidance should also be put in clearer language, so that the blended models are well understood by finance teams and by clinicians.

Providers' capacity to innovate to reduce bed occupancy might be limited if there are not corresponding changes to counting and coding notices in the standard contract. This is because it will be difficult for clinicians to move activity from day cases to outpatients when there is not an identifiable HRG for that procedure.

Blended payment for maternity services

2 To what extent do you support this proposal? *Neither support or oppose*

We recognise the need to change the payment system across maternity services, though there are likely to be difficulties in implementing the blended model.

The use of tolerance levels for fixed payments should accommodate variance in patient flows. However, during the first year of blended payments in maternity services, these levels may be surpassed before a risk sharing agreement is put in place. Providers and commissioners should be encouraged to develop risk sharing agreements at the outset of adopting the blended model.

It is positive that more clarity has been provided about how trusts will be reimbursed for treating patients outside of their local maternity system (LMS). However, further clarity is needed about how provider-to-provider transactions across maternity services can be substantially reduced. It will also be difficult for LMSs to coordinate financial flows across several organisations. Commissioners and finance teams across LMSs will be required to share activity and cost data to ensure that providers are adequately recompensed.

It is vital that system partners share financial and activity information across LMSs, otherwise it will make calculations of predicted activity levels more difficult. However, the capacity to establish robust data sharing arrangements for maternity services by the end of 2020/21 will depend on the maturity of each LMS.

While there is a need to change the payment system for maternity services, providers are also concerned by the further cost pressures that may result from the implementation of the blended model. To ensure the delivery of the Better Births objectives – such as implementing the continuity of carer model – trusts might face short-term cost increases when no additional funding has been allocated towards the quality improvement schemes.

The tariff document recommends that system initiatives proposed by LMSs – but not covered by current prices – should be ‘considered’ in finalising the fixed payment. However, it is vital that CCGs are made aware of the need to support LMS plans, and that activity outside of the scope of the tariff is still reimbursed. Also, as there will be cases where there are multiple CCGs in an LMS, it will be necessary to share the result of the pilot where a lead commissioner is appointed for an LMS.

The extent to which these cost pressures are mitigated will also depend on how earnable the quality- and outcomes-based measures are. A focus on quality- and outcomes-based measures is welcome, but NHSE/I should recognise that upfront investment is likely to be required to deliver the personalised care outcomes, which could increase providers’ costs, and which may not be recompensed through the fixed or risk-sharing elements of the blended model.

We welcome that the needs of marginalised groups of women are explicitly recognised in the document. Commissioners and providers should be mindful of the need to ensure agreed activity levels take into account women from the most deprived populations and from BAME groups.

3 Do you have any other comments on blended payments?

NHS Providers is pleased that NHSE/I has responded to concerns from the provider sector about the pace of change for maternity services and adult critical care. The final proposal demonstrates a less rigid approach to implementation than was suggested in the tariff engagement document.

Trusts’ concerns over implementing the blended model relate to the difficulty in establishing baselines. While there is more detail in the statutory consultation document about the process by which forecasts are developed, trusts must be reassured activity levels will be forecast on previous year’s outturns and

continuing trends. Commissioners should not place unrealistic expectations upon providers by setting overly ambitious forecasts.

NHSE/I should be aware of the difficulty in establishing thresholds for fixed elements with commissioners outside of a provider's local system. There may be competing incentives between different systems, which will make it harder to come to agreement over baselines.

Quality- and outcomes-based payments should be made as a reward for good performance, rather than being a penalty topsliced from a provider's contract value and earned back. The guidance document warns this would be difficult 'in a financially constrained environment'. In the past, there have been concerns over how earnable additional payments are for national quality incentive schemes. We therefore suggest that in the development of outcomes-based payments, NHSE/I does not create another layer of financial risk that sits solely with providers, and instead encourages and rewards real system collaboration.

The broader concern about blended payment models is that the calculations of the fixed element could prove to be extremely complex. As many trusts already use block contracts with risk-sharing elements attached, providers should be made aware of the differences and similarities to blended payment contracts, and more examples should be provided about how the fixed elements for blended payment models should be agreed. Ideally, patient-level data will be used in the future to create a fair and cost-reflective fixed payment, though as the guidance document highlights, this demands data collection methods not currently available to all providers.

Risk-sharing arrangements could mitigate some of the errors in forecasting which may create additional financial risk for providers. We would like to see further evaluation and consultation with providers and commissioners about the extent to which risk-sharing agreements have been constructive in developing contracts, as well as data showing how these agreements supported providers when activity thresholds were surpassed.

It is encouraging that NHSE/I recognises the importance of determining outcomes on a local level. Locally developed quality- or outcomes-based approaches will take time for system partners to develop and agree. It is vital for providers to become secure in establishing desired outcomes with their commissioners, before considering how outcomes and payment models are constructed at a system level.

We welcome that NHSE/I recognises the limits of payment reform alone in being able to deliver system transformation: blended payments are only one of the many enablers of change. To ensure more joined-up care – such as ensuring greater integration with primary care, and supporting people with multiple and long term conditions – new payment models must enable, accompany and support wider system reforms. The ambitions of the long term plan demand improvements to governance, collaborative system leadership, and comprehensive data about the local population and health and care services. Moreover, if the intention is to adopt blended models across entire pathways, it will be necessary to find ways to adapt the blended model to promote better treatment of long term conditions.

The blended payment frameworks already introduced in UEC and mental health services should be comprehensively evaluated and the results shared so that the impact of these changes can be properly

understood. The provider sector should be made aware of the uptake of the blended model, the nature of the negotiations between commissioners and providers, and the financial and operational impact it has had.

It will also be useful for the sector if NHSE/I provided a dataset of the payment mechanisms used by trusts, so trusts can learn from others currently employing blended models. An analysis of the savings and efficiencies, and of potential outcomes that systems can be encouraged to adopt should also be provided, with minimal disruption or burden placed on the provider sector.

Currency design and specification

4 Currency design – To what extent do you support this proposal? *Neither support or oppose*

5 Scope of currencies – To what extent do you support this proposal? *Neither support or oppose*

Given the intention is for UEC, outpatient attendances and maternity services to adopt blended payments, it seems sensible to exclude them from national prices.

6 Chemotherapy services – To what extent do you support this proposal? *Neither support or oppose*

We agree with the rationale for removing the need for separate invoicing of these drugs, and to ensure a consistent approach to the procurement and payment of chemotherapy delivery services. However, as these drugs were not included within reference cost calculations, trusts are concerned about how precise the identified value of supportive drugs is. The chemotherapy delivery tariff might underestimate the value of supportive chemotherapy drug spend.

NHSE/I should also be mindful that the proposed changes are unlikely to reduce the administrative burden placed upon providers in terms of reconciling payments. Trusts will still have to report the use of individual supportive drugs, and will have to reconcile payments throughout the financial year.

7 High cost exclusions – To what extent do you support this proposal? *Neither support or oppose*

Providers have expressed concern about reimbursing cancer genetic testing activity outside of the national tariff. It is unclear to trusts whether the change will be cost neutral, given the potential growth in activity following new commissioning arrangements and the adoption of new technologies. It has been difficult for trusts delivering cancer genetic testing activity to understand the calculation of the £77.8m

which will be removed from the national tariff, and hard for these providers to assess the potential impact of the change. Moreover, trusts have highlighted the risk that the national test directory will not be adequately updated, and therefore cancer genetic activity may not be priced and reimbursed correctly.

8 Innovation and technology tariff/innovation and technology payment – To what extent do you support this proposal? *Neither support or oppose*

9 Best practice tariffs – To what extent do you support this proposal? *Neither support or oppose*

There is still a risk that providers will see a fall in revenue for the acute stroke best care practice tariff payment. There are likely to be factors outside of a trust's control that will limit their ability to ensure patients are assessed by a stroke specialist within a one-hour time window.

10 Ambulance services – To what extent do you support this proposal? *Neither support or oppose*

If NHSE/I intends to expand the scope of blended payments to emergency care to include emergency ambulance services, more work must be carried out with ambulance trusts to establish the advantages and disadvantages of changing reimbursement methods.

National prices

11 Setting a one-year tariff – To what extent do you support this proposal? *Tend to support*

Given the context of the proposals, and given there is currently a lack of uniformity across payment systems, we are in support of establishing a one-year tariff for 2020/21. However, over the long term, providers will require more certainty over their baseline allocations. NHSE/I should therefore work towards setting the tariff for a longer period of time after 2020/21 to support the long term ambitions of the sector, as set out in the long term plan.

12 Setting prices for 2020/21 – To what extent do you support this proposal? *Neither support or oppose*

We are in favour of rolling over the price relativities from the 2019/20 NTPS rather than calculating new price relativities.

- 13** Managing model inputs for 2020/21 – To what extent do you support this proposal? *Neither support or oppose*
- 14** Setting prices for best practice tariffs for 2020/21 – To what extent do you support this proposal? *Neither support or oppose*
- 15** Making manual adjustments to prices – To what extent do you support this proposal? *Neither support or oppose*
- 16** Cost base – To what extent do you support this proposal? *Neither support or oppose*

It seems appropriate to use the same cost base as the 2019/20 NTPS.

While we agree with the proposal to make no further adjustments to the tariff relating to the arrangements for the NHS Supply Chain Coordination Limited (SSCL) for 2020/21, we would like to reaffirm that providers should not have had to fund the SCCL via a topslice in the 2019/20 NTPS. It would be better if SCCL's running costs were funded via a mark-up on product prices. However, it is positive that NHSE/I have listened to the provider sector and decided to not increase the topslice, regardless of any increase in SCCL's overhead costs.

- 17** Cost uplifts – To what extent do you support this proposal? *Neither support or oppose*

It is not clear whether the 2.9% cost uplift for pay in 2020/21 will reflect the impact of pay inflation following pay awards and incremental uplifts over 2019/20.

- 18** Efficiency factor – To what extent do you support this proposal? *Tend to support*

We are in favour of retaining the efficiency factor at 1.1%, which seems a reasonable stretch target given that the sector trend efficiency figure is 0.9%.

National variations and locally determined prices

- 19** Market forces factor – To what extent do you support this proposal? *Neither support or oppose*

While NHSE/I are not making any changes to the market forces factor's underlying data for the 2020/21 NTPS, it is important to take into account trusts' objections during the engagement process to the methodology used to calculate the values.

- 20** Evidence-based interventions – To what extent do you support this proposal? *Neither support nor oppose*

- 21** Top-up payments for specialised services – To what extent do you support this proposal? *Neither support nor oppose*

- 22** Local pricing rule for high cost drugs, devices and listed procedures – To what extent do you support this proposal? *Neither support nor oppose*

Additional comments

The purpose of the tariff should be considered alongside the wider financial architecture review. A functional tariff system would give well-managed trusts the ability to invest in their services when they generate surpluses, and the separation of tariff prices from providers' running costs has been a key driver of unsustainability in the provider sector in recent years. The tariff must support the provider sector as a whole to return to a balanced position by 2023/24, as set out in the long term plan, and trusts with structural deficits should be taken into consideration in the development of new payment systems.

Blended payment models could in theory be used to trace the payment of care across an entire pathway, such as respiratory care. The current proposals do not suggest how this may work, though if this is the intended direction of travel, NHSE/I should be mindful of the complexity of tracking financial flows across systems.