NHS Providers response to 2021/22 tariff proposals

Were a financial framework based on the broad principles set out above to be proposed, to what extent would you support such a move? *Neither support nor oppose*

Trust leaders remain positive about the opportunity to improve health outcomes, reduce health inequalities and improve sustainability via system working and deepening local collaboration. They agree that integrated care systems are becoming increasingly valuable in bringing local health and care organisations together and facilitating joined up care, as the current pandemic shows. There are already many positive examples of collaboration between providers and their systems.

Providers broadly feel that allocating funding to systems can work, but there must be a shared understanding of how ICS funding envelopes are calculated. Currently, NHSE/I determines the allocation of financial resources to CCGs using a published statistical formula, which is based on academic research and overseen by an independent external group. This transparency and rigour must not be lost.

We have heard concerns that some systems may not yet have developed a good enough collective knowledge of how all local services are run or funded. Where the specific financial issues facing, for instance, mental health or community services are not properly understood by the system as a whole, it could result in the case for investment in those services not being given adequate attention.

Likewise, financial problems related to structural issues, for example geographic factors including rurality, may not be fully understood by all members of an ICS. Systems without a well-established record of mutual support and joint working will therefore be less likely to make investment decisions based on a full, shared understanding of their collective challenge

NHSE/I should also work with providers to define a clear vision for specialised services, using this to help ensure that proposed changes to the financial framework do not introduce unnecessary complexity or risk and are in the best interests of patients.

How do you think financial governance in your system would need to develop in order to support such a financial framework, were it to be implemented?

ICSs developed from different starting points and have not all done so at the same pace. Taking complex decisions concerning the distribution of funding and ensuring that allocations are spent appropriately will be new responsibilities for most systems, yet they are due to be given identical financial responsibilities from 2021/22 onwards. The risks of this approach include complex and protracted rounds of negotiation, and decisions made on the basis of local dynamics and relationships (rather than clear principles and processes).

Members tell us that giving ICSs a decision-making role over finances can work, as long as there is clear guidance on how funding should be distributed to individual organisations and a shared belief that the arrangement is fair. With systems taking an increasingly central role in local budgeting, it will be necessary to clarify the governance and accountability arrangements they will be subject to, and how these will interact with trusts' existing statutory responsibilities. It will be particularly important to set out how to resolve cases in which the interests of the system conflict with the interests of an organisation.

NHSE/I must recognise and support different levels of ICS maturity. It can do this by establishing universal system accountabilities and default governance arrangements that outline who has the power to make decisions, the decision-making process and how this all aligns with providers' existing statutory responsibilities. More mature systems should be allowed to develop their own governance arrangements, as long as they abide by the same overarching accountabilities and have mechanisms in place to ensure that funding envelopes are fairly distributed to individual organisations within the system.

Are there any areas in addition to the key considerations that you think we should be focusing on in developing a future financial framework?

There has been very little discussion to date of how financial regulation could work at a system level. For example, the consequences associated with a loss of financial control within a system have not been set out, either in terms of a formal special measures regime or any other regulatory action. Finance leaders are not yet clear to what extent accountability for financial challenges will sit with provider and/or system financial leads.

It must be made clear to trusts and systems what the consequences of success or poor performance will be. The regulatory framework must keep pace with the evolution of the payment system, and financial regulation needs to stay aligned with operational performance and quality and safety.

Do you have any other comments on the potential 2021/22 financial framework?

NHSE/I must shape the 2021/22 financial framework based on meaningful engagement with acute, community, mental health and ambulance providers, with a particular focus on setting a realistic pace of change that reflects ongoing operational pressures and uncertainty about the impact of COVID-19 in the months ahead.

To what extent do you agree that the blended payment approach described would support the objectives of the NHS Long Term Plan? *Don't know*

To what extent would you support setting the scope of blended payment for almost all services covered by the national tariff? *Don't know*

Further detail required.

To what extent would you support setting a fixed payment based on the costs of delivering a level of activity that conforms to the ICS system plan? *Neither support nor oppose*

Trusts recognise the benefits of basing contract values on providers' cost base rather than national tariffs. For example, this will help providers account for local variations in facilities costs, workforce constraints and geographical limitations that have an impact on efficiency gains. However, some providers have told us they do not want to lose the rewards associated with good financial performance which were built into the PbR system, nor the focus on containing costs.

The feedback we have received to date suggests that providers are concerned that the calculation of the fixed element of blended payment may prove complex for some systems, particularly when patient-level data is limited.

NHSE/I should publish a default methodology to help providers and commissioners agree the fixed element of blended payment based on cost base. This needs to be accompanied by clear guidance on dispute resolution and how changes in the external environment, such as subsequent waves of COVID-19, can be accounted for. NHSE/I should also set out the circumstances under which alternative approaches to the blended payment model would be permitted.

NHSE/I should also clarify how good financial performance will be defined and rewarded, and how providers in deficit will be supported to return to a sustainable financial path. A shared understanding of each provider's starting position, including their relative cost efficiency, is essential.

To what extent would you support the fixed payment including items currently excluded from the tariff, such as high cost drugs and devices and genomic tests? *Don't know*

Further detail required.

To what extent would do you support including a variable element for some elective activity in the blended payment? *Don't know*

Further detail required.

To what extent would you support having a threshold provider/commissioner contract value below which the blended payment arrangements would not apply? *Don't know*

Further detail required.

To what extent would you support host CCGs paying for activity below £0.2m, with allocations adjusted to compensate? *Neither support nor oppose*

Further detail required.

What would be your preferred default payment approach for contracts valued between £0.2m and £10m? *Don't know*

Further detail required.

To what extent would you support retaining national prices for diagnostic imaging services? *Neither support nor oppose*

To what extent would you support a Standard Contract requirement for a System Collaboration and Financial Management Agreement alongside a blended payment, to help share risk across a system? *Don't know*

While we await further detail on what this may entail, NHSE/I should be mindful of the concerns raised about system financial governance, as ICSs remain reliant on the individual statutory underpinnings of each of their component partners.

The relative maturity of commissioning functions as they consolidate and move to become more strategically focussed, and aligned with a footprint in most cases, will also have a bearing on how the standard contract operates in future years. as commissioning becomes more strategic, it seems logical to expect a paring back of the detailed provisions within the standard contract.

We would like to see further detail about how a System Collaboration and Financial Management Agreement will facilitate risk-sharing across systems. The importance of system maturity and existing relationships may prove to be more impactful than contractual requirements.

To what extent would you support a review of the financial sanctions for failure to achieve national performance standards in the NHS Standard Contract? *Don't know*

Further detail required.

To what extent would you support the retirement of the day case and outpatient procedure BPTs if their financial incentives are replicated in a blended payment design? *Don't know*

Further detail required.

To what extent would you support BPTs becoming non-mandatory with guidance on how to capture them within any blended payment agreements? *Don't know*

Further detail required.

To what extent would you support the further integration and streamlining of financial incentives in future years? *Don't know*

Further detail required.

To what extent would you support setting the 2021 tariff for one year? *Support*

Given that previous assumptions regarding efficiency factors, inflation, cost-base, and case-mix have been distorted during the pandemic, it is sensible to set the 2021 tariff for one year and to revisit the indicative prices again next year. However, the provider sector would also welcome more detail on the direction of travel for the use of the tariff beyond 2021/22.

To what extent would you support a local guidance framework for adjusting prices to account for costs arising from Covid-19? *Strongly support*

Ongoing COVID-19 costs that will invariably affect case-mix and activity levels. Guidance for local agreement will therefore be welcome and instructive for providers and commissioners.

If this approach were taken, what type of guidance do you think would be most useful (1) detailed rules with standardised national requirements or (2) looser framework to be flexibly applied locally? Please explain the reasons for your answer

To what extent would you support setting prices for 2021/22 by rolling over the price relativities and currencies from 2020/21? *Don't know*

Further detail required.

To what extent would you support making no further adjustments to the tariff to reflect the arrangements for the central funding of overhead costs of Supply Chain Coordination Limited (SCCL)? *Support*

Further detail required.

To what extent would you support continuing to pause the specialist top-ups transition path for 2021/22? *Don't know*

Do you have any comments on the potential approach to specialist services top-ups for 2021/22?

Further detail required.

To what extent would you support making no substantial changes to the high cost drugs and devices lists for 2021/22? *Don't know*

Further detail required.

To what extent would you support moving to the next (third) step of the MFF glidepath introduced following the 2019/20 data and method update? *Don't know*

What would be your highest priorities for any future payment system? *Don't know*

There is not a clear consensus on behalf of the whole provider sector about what the highest priority should be.

If they were implemented, what impact do you feel the policies outlined are likely to have on equality and addressing health inequalities? *Don't know*

Do you have concerns that there are distinct groups with protected characteristics that our policies may impact negatively?

This is an important question but providing a meaningful answer would require further detail.