NHSProviders

NHS Providers response to the 2023/25 NHS payment scheme consultation

On 23 December 2022, NHS England (NHSE) launched the formal consultation on proposed changes to the NHS payment scheme (NHSPS) and standard contract. The full consultation notice and all supporting material can be found here. You can also read NHS Providers on the day briefing on the consultation notice here.

Please find below NHS Providers' response to the statutory consultation notice.

Accepting or rejecting the proposed NHS Payment Scheme

1 Do you accept or reject the proposed 2023/25 NHS Payment Scheme? *Accept*

Proposals applying to all payment mechanisms

2 To what extent do you support the proposed two-year NHSPS? *Tend to support*

Trusts are broadly supportive of NHSE's proposal to set the NHS payment system for the next two financial years. Establishing a clear financial framework gives providers and commissioners greater financial certainty and stability to enable the delivery of their operational plans.

Providers would value as much transparency and notice as possible when updating the proposed prices for 2024/25. When NHSE makes further changes to the payment system for 2024/25, trusts expect to be fully engaged with to share their views ahead of any adjustments to the financial framework.

3 To what extent do you support the proposed payment principles? *Tend to support*
Payment principles will help guide discussions between providers and commissioners. Improvements in efficiency and productivity are already at the forefront of trust leaders' minds.

4 To what extent do you support the proposed cost uplift factor? *Neither support or oppose*

Trusts will welcome that NHSE has assumed a higher GDP deflator than the Office for Budget Responsibility's estimate, following the undervaluation of inflation for NHS providers in its previous

forward-looking estimate. Finance leaders across the provider sector have however challenged the accuracy of the GDP deflator as a measure of inflation across the health sector. Inflation in the wider economy remains well above the government's own target and it continues to reduce the real terms value of system allocations.

Non-acute providers remain concerned about the cost weighting used to calculate the cost uplift factor for 23/24. As the consultation states, the cost weights used in this calculation are based on previous cost uplift factors and assume an average cost spread which is representative of all provider organisations. Non-acute providers have consistently highlighted why their cost profile is considerably different from acute providers. For example, a much higher proportion of their total costs relate to pay costs. We appreciate that the availability of data from non-acute trusts may make it more difficult to accurately disaggregate their cost bases but would appreciate NHSE's commitment to continue working with us on this issue.

We understand the pay-cost estimate used in the calculation of the cost uplift factor does not pre-judge the outcome of the pay review body process. However, providers remain concerned that national (and potentially system) funding shortfalls may be generated as a result of a pay award uplift exceeding the 2.1% nominal estimate (accounted for within current allocations). Trusts want to avoid the same situation as last year where additional funding had to be identified from within the NHS core budget to top-up system allocations resulting in cuts to, or a slowing down of investment in important national programmes.

5 To what extent do you support the proposed efficiency factor? *Neither support or oppose*

Trusts appreciate the need to deliver sustainable efficiencies and continue to provide the best value for the taxpayer. We note NHSE considers the proposed 1.1% efficiency factor as a stretching but achievable target. However, trusts are concerned that the efficiency ask for 2023/24 may be more challenging than 2022/23, given inflationary pressures, operational demands and productivity constraints, and following the withdrawal of non-recurrent COVID-19 funding.

In addition, trusts are concerned that the calculation of the efficiency factor for 23/24 is largely predicated on efficiency data from acute providers only. We understand that the lack of availability of data from non-acute providers makes it difficult to incorporate this into any calculation of the efficiency factor but as above, we would appreciate NHSE's commitment to improving the information available to ensure that community, ambulance and mental health providers can be more accurately factored into these decisions, over time.

6 To what extent do you support the proposal to update cost and efficiency factors for 2024/25 using a formula? *Tend to support*

As above, trusts value setting the NHS payment system for the next two financial years, providing them with greater stability to enable long term financial planning. It is important for NHSE to be transparent about the calculations underpinning the formulae for 2024/25.

Do you have any comments on the proposed formula?

As set out above, finance leaders across the health service continue to have concerns about the accuracy of the GDP deflator in capturing the true level of inflation across the health service. Trusts would welcome input from a variety of sources, including any internal analysis conducted by NHSE, to assist in accurately calculating the level of inflation across the health service.

7 To what extent do you support the proposed approach to excluded items in the NHSPS? *Neither support or oppose*

8 To what extent do you support the proposed approach to best practice tariffs (BPTs)? *Tend to support*

We are broadly supportive of moving the agreement of BPTs which are not related to elective activity to an annual process. Trusts will welcome the removal of in-year adjustments with regards to performance against BPTs. This will give them more clarity about their financial envelope for the year and will reduce the administrative burden associated with continual monitoring of BPT performance.

Payment mechanism: Aligned payment and incentive

9 To what extent do you support the proposed scope of the API payment mechanism? *Neither support or oppose*

We welcome the continued commitment to applying the aligned payment and incentive (API) model across nearly all NHS provider-commissioner relationships. This will help enable greater collaboration between providers and commissioners across systems. Additionally, by ensuring NHS providers use the same payment approach, NHSE reduces the possibility of regional variations which could further embed inequalities.

Trusts are concerned that the removal of the £30m threshold for the API will result in a substantial increase in trusts' administrative burden, given that low value contracts are now in scope. Given the difference between the previous £30m threshold for API arrangements and the £0.5m threshold for LVA arrangements to apply, it is a concrete possibility that a large volume of contracts will now need considerably more administrative attention under the API approach. This may add a further layer of complexity to providers' contracting arrangements.

10 To what extent do you support the proposed design of the API fixed element? *Neither support or oppose*

Trusts value the provision of detailed guidance to help inform setting the fixed element. Trusts are broadly supportive of the continuation of the fixed element to cover the majority of funding, giving them the financial stability they need to drive performance improvements and deliver on key operational priorities.

We agree with the principle that the fixed element should be framed around an agreed level of activity. The mandate given to system leaders is that such targets should be "stretching but achievable". Integrated care boards (ICBs) must continue to work collaboratively with providers to determine realistic and deliverable activity targets to underpin the fixed element.

Commissioners must consider the factors outside of providers' control which may hamper their ability to meet activity. Systems should show flex against initial targets throughout 2023/24. We welcome NHSE's provision of tools used to assist providers and commissioners in negotiations to this effect.

11 To what extent do you support the design of the elective variable element? *Neither support or oppose*

Trusts recognise the need to drive up activity levels and deliver on the key priorities of the elective recovery plan. Finance leaders across the acute sector found the operation of the 22/23 elective recovery fund challenging to build into financial planning. Trusts value early and unambiguous guidance which clearly sets out the process for reimbursement.

There are mixed views across the sector about the most effective way to significantly ramp up elective activity. It is currently unclear how much of an impact the financial levers have in driving up activity levels in the current operational context. Trust leaders note that it is not the operation of the payment system which is currently limiting the pace of elective recovery. Workforce productivity constraints, limited bed capacity and restricted patient flow are currently major obstacles to improving performance. Some trusts are also concerned that moving closer to an activity-based model for elective care will work against many of the behaviours providers are trying to embed, given the move to closer collaboration and a greater focus on prevention and population health within systems.

We are aware that a range of trusts – including both small and large acutes –intend to reject the proposals in light of the variable element for elective activity. Trusts are concerned that linking most elective reimbursement to activity levels, at fixed unit prices, will significantly challenge their capacity to improve their underlying run-rate across 2023/24. They are concerned by the levels of financial risk their organisations will have to carry if they underperform against activity targets, and that the elective care tariff may not accurately cover the real cost base for delivering activity.

Providers would also the freedom to deviate from the "default" system should they have an alternative funding mechanism agreed with commissioners in their local system. Providers, along with their system partners, should be given the opportunity to explore innovative solutions to determine the most effective way of improving performance. Some trusts are concerned that the financial framework may not accurately

capture, incentivise and reimburse innovations across specific patient pathways. It is vital providers do not lose income when they deliver material productivity improvements which are not adequately reimbursed by specific unit prices.

For example, there may be value for some systems in allocating ERF funding to providers based on their progress towards reducing waiting lists, instead of overall activity levels. This would align with the key priorities set out in the operational planning guidance and increase activity levels as well. Linking ERF funding to waiting lists could also remove the potential and risk of some of the more perverse behaviours seen in the PbR era becoming more prevalent. NHSE should consider the value of enabling greater flexibility across systems to determine a variable element which delivers the best results for their area.

We remain concerned that the proposed model is heavily skewed towards the acute sector. Community and mental health providers are similarly faced with care backlogs and rising demand, with a need to increase and expand capacity and bring down similarly long waiting lists.

12 To what extent do you support the design of the CQUIN variable element? *Tend to support*

The introduction of the £10m threshold for CQUIN to apply to contracts, and the reduction of the number of CQUIN indicators, will be welcomed by providers. Streamlining the scheme will reduce the administrative burden for trusts whilst ensuring that quality of care remains a pillar of performance monitoring. We welcome NHSE has selected indicators which have support from clinicians and which should remain realistically achievable.

13 To what extent do you support the proposed payment rules for specialised services? *Neither support or oppose*

We share the same view as NHSE that there should be differentiated payment arrangements for specialised services. Trusts would welcome specific guidance on such services in order to ensure that they are appropriately reimbursed, especially for those services which are expected to be included within the API fixed element.

14 To what extent do you support the design of the proposed approach to variations from the default API design? *Neither support or oppose*

Payment mechanism: Low volume activity (LVA) block payments

15 To what extent do you support the proposed scope of LVA arrangements? *Neither support or oppose*

16 To what extent do you support the proposed LVA design? *Tend to support*

We support the overall design of the LVA approach. Trusts report it has been central to reducing the administrative costs for low-value contracts. Trusts have flagged that due to the comparably low levels of activity in 21/22, as a result of the continued prevalence of COVID-19, the block payment will not match providers' cost base (which has since remained unchanged) and the income received will be disproportionately low.

Payment mechanism: Activity-based payments

17 To what extent do you support the proposed scope of activity-based payments? *Neither support or oppose*

18 To what extent do you support the proposed activity-based payment design? *Neither support or oppose*

Payment mechanism: Local payment arrangements

19 To what extent do you support the proposed scope of local payment arrangements? *Neither support or oppose*

20 To what extent do you support the proposed local payment arrangements design? *Neither support or oppose*

Prices: role, calculation and related adjustments

21 To what extent do you support the proposed role of prices in the 2023/25 NHSPS? *Tend to support*

Trusts will welcome the clear differentiation between unit prices (for elective activity) and guide prices (used as a benchmark for non-elective prices). Providers and commissioners should be empowered to enter local negotiations with clear benchmarks in place to support discussions.

22 To what extent do you support the proposed approach to calculated 2023/24 NHSPS prices? *Neither support or oppose*

Trusts understand the distortive effect COVID-19 has had on price setting and can understand the continued use of 18/19 cost and activity data as the benchmark for 23/24 prices. However, the calculation methodology for NHSPS prices does not accurately capture the cost-base and case-mix that providers are actually facing.

23 To what extent do you support the proposed changes to price relativities? *Neither support or oppose*

24 To what extent do you support the proposed revision of data used to set market forces factor values? *Neither support or oppose*

There continues to be mixed views across the provider sector on the methodology used to calculate the market forces factor. We support NHSE's proposal to update the source data. However, revising the data underpinning the market forces factor may lead to a reduction in income levels for some trusts despite overall cost bases remaining unchanged. Going forward, the methodology must accurately capture the external environment faced by trusts and ensure income levels are not disproportionately reduced.

Future payment system development

25 What national support would you find most helpful in agreeing payment arrangements in future?
Direct support, guidance, case studies, data, tools would all be helpful.

We welcomed the numerous engagement workshops conducted throughout the year as a vehicle for which providers could share real-time feedback with NHSE on how various elements of the payment system was working.

Health inequalities and any other comments

26 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*

We welcome the focus NHSE has placed on addressing health inequalities within the payment system, including tackling health inequalities as one of the payment principles. However, there is little detail within the draft payment scheme to assist trusts in accurately measuring the impact of payment approaches on health inequalities. We recognise the complexities in capturing place-based impacts of funding allocations, and that inconsistent and limited datasets make it challenging for systems to effectively model the inequalities implications of commissioning decisions. Given this, providers would value further guidance and qualitative/quantitative assessments to specifically address this concern.

27 Do you have any other comments on our proposals for the 2023/35 NHS Payment Scheme?
Finance leaders note the value in providing guidance about how best to capture and record virtual outpatient appointments. Trusts are concerned that the difficulty in capturing this activity may lead to omissions of data that would otherwise reflect improvement against national targets.