19 February 2019

NHS Providers

National tariff payment system 2019-20 statutory consultation: 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 messages

- The NHS national tariff payment system does not operate in isolation. Since the publication of the initial national tariff proposals in October 2018, we have received further details on the overall 2019/20 financial settlement, which we have broadly welcomed. Our response now takes into account the impact of the new financial recovery fund (FRF) and provider sustainability fund (PSF) changes.
- We note the quality of NHS Improvement's engagement on the tariff proposals since the summer and we feel the provider sector has been listened to.
- We continue to support the stated ambitions of the 2019/20 national tariff payment system proposals: 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 do not feel reasonable concerns have always been acted upon. NHS Providers is therefore disappointed over the minimal changes that have been made to the proposals since the October consultation.
- Delays over publication of these proposals and other national policy guidance have left providers and commissioners little time to negotiate and implement payment reforms. As in previous years, we would stress the importance of timely publication of these important documents to support productive and meaningful planning and contract negotiations.

Engagement

We welcome the opportunity to engage on the tariff proposals for a second time. Throughout the development of the tariff there has been reasonable informal engagement with trusts and the wider NHS, which has enabled trusts to give constructive feedback. NHS Providers supports the collaborative approach NHSI continues to take in sourcing providers to input into the impact assessment. Regular communication, through email bulletins and workshops, has been appreciated.

Nevertheless, the timescales between consultation and implementation have slipped back compared to previous tariff consultations. While we appreciate there were some delays to the proposals because of the announcement of the five year funding settlement in the summer, we are disappointed over the shortened engagement timescales. This will make implementation much more difficult than in previous years, particularly with the radical changes proposed to urgent and emergency care and mental health services. Ideally, we would have liked to have seen more flexibility around implementation and lead-in times. In addition to this, providers would have welcomed greater detail in the October consultation around certain proposals, such as the mental health blended payment system, as this may have helped lay the groundwork for later negotiations.

Timescales

One year tariff

Although in the long term we support the greater stability and certainty offered by multi-year tariffs, we understand that the present circumstances are unique. Making 2019/20 a "transitional" year is an appropriate response to the challenge of agreeing a tariff for the coming year while simultaneously drawing up a long term plan for the NHS covering the next five years. We hope the multi-year approach begun for the 2017-19 tariff will be resumed and built upon from 2020 and beyond.

However there remains a lack of clarity so far on the nature and extent of the transition that will continue beyond 2019/20. This means that major reforms are being made to some payment systems – for example mental health or emergency care – without there being a clear description of how these changes support a desired end state.

Implementation

Delays to the publication of the initial engagement documents, the formal tariff consultation, and the planning guidance have compressed the timescale for agreeing new contracts. Adopting the new, significantly different contract structures for emergency and mental health services will require additional resource and attention. Compounding the issue, both new "blended" payment systems involve more planning before the year begins, and potentially difficult negotiations with commissioners about activity levels.

Trust leaders have expressed their concern at the impact on finance teams of the combination of compressed timescales, new contractual forms, and usual end-of-year demands.

Efficiency factor

We are pleased to see an efficiency factor of 1.1% that more closely resembles the historical average performance that the NHS has achieved in recent years. However, the requirement for trusts in receipt of financial recovery funding – that is, almost the entire acute sector – will be higher. This is despite it not being clearly demonstrated that those trusts are less efficient than those not eligible for FRF, or that an additional flat 0.5% is an appropriate and achievable requirement to apply to FRF trusts. As a result, we are

concerned that providers receiving FRF will find it difficult to hit their efficiency target, and could therefore face prolonged deficits.

Unfunded cost pressures

Since the initial proposals were published in October, trusts have raised two major unfunded cost pressures that we are concerned have not been factored into the tariff.

Local authority funded staff

Trusts are facing a material cost pressure where they employ Agenda for Change staff to deliver services commissioned by local authorities. This is because the pay deal struck in 2018 entitles all AfC staff to pay increases, and for 2019/20 this is being funded centrally via a 5% increase in the tariff for NHS commissioned services. However local authorities are not able to increase contract values, and do not have access to central funding to pay for AfC pay rises. As a result trusts providing local authority funded services and employing AfC staff are in a position where they will be obliged to fund nationally-agreed pay rises without a commensurate increase in contract value.

Agenda for Change pay rises have a greater proportionate impact on council-funded contracts, which are usually for public health services, than for NHS contracts. This is because those services tend to use a higher proportion of nurses and allied health professionals, and fewer medical staff, than NHS services.

Compounding these issues, council funding, and consequently contract values, has been cut severely since 2010. The result of this is that there is even less scope in these contracts to find efficiency savings to account for this additional pressure.

For 2018/19 £800m was made directly available to trusts to pay for the AfC pay increase – although this was never enough to cover the full cost, as a blanket 2.9% “scaling factor” was applied. In spring 2018, when the issue of AfC staff funded via local authority contracts first emerged, it was agreed that pay rises for these employees should be centrally funded. This was because it was not considered credible to make resource available for NHS-funded AfC staff, but not those providing local authority-funded services.

However this principle has not been used for 2019/20 and beyond. Instead, the £800m funding for 2018/19 is being routed through the tariff, along with provision for 2019/20. While the NHS tariff is uplifted to account for the 2018/19 and 2019/20 pay increases, there arises a cost pressure equivalent to the value of two years of pay rises for local authority-funded staff. This will translate into a shortfall in the low millions for many providers of public health services, and is therefore enough to make a trust’s control total unrealistic.

Agenda for Change terms and conditions are agreed by the government, and, it is logical that national provision be made to fund pay rises for all employees under the framework.

Depreciation charges

Trusts face a possible unfunded cost pressure relating to depreciation charges. This has been brought about because of an update in November 2018 of guidance published by the Royal Institution of Chartered Surveyors on how organisations should account for asset depreciation. Under the revised guidance, trusts have been advised by external valuers that they would need to adjust their assumptions of the useful life of an asset. As a result, trusts are being advised to increase their annual depreciation charges. This would leave trusts with material cost pressures which are not funded in the tariff. Trusts need clarity from national bodies on whether the Royal Institute of Chartered Surveyors guidance must be adhered to or whether existing accounting approaches, which can lead to lower depreciation charges, can remain in place.

Changes to incentives and penalties

NHS Providers welcomes the abolition of the marginal rate emergency threshold (MRET) and 30 day readmission rules, which we have long campaigned for. But, as we argue below, the introduction of the blended payment system for urgent and emergency care simply recreates problems brought about by the original MRET rule. In fact, for some providers which have negotiated lenient MRET arrangements with their local commissioners, or have suspended these arrangements entirely, there is a risk that the introduction of blended payments could represent a significant cost pressure. Furthermore, in 2019/20 original MRET money will be subject to control total sign up, and will be paid on a quarterly basis. Therefore the blended payment system and the central withholding and payment in arrears of MRET monies could combine to cause a significant impact on cash flow for providers.

In principle we support the decision to share 52 week wait fines between trusts and commissioners. By placing sanctions on both parts of the system, the contract accurately reflects the fact long waits can only be addressed by systems rather than via punitive sanctions on individual organisations. But because this fine is being reintroduced into the contract it will, where used, ultimately represent an unhelpful additional cost pressure for many trusts.

We strongly welcome the reduction in CQUIN values, with funding mainstreamed through tariff prices. But again, we note that providers are awaiting further information, to be published CQUIN guidance. This is making it difficult for trusts to negotiate, in particular smaller value contracts because of the small-value contract exception rule.

Average uplifts for different sectors

It is proposed that providers of acute services will be given additional money to enable the abolition of MRET, while a further £1bn will move from the provider sustainability fund (PSF) into the tariff for emergency care. The effect of this is that the 2019/20 tariff proposals give the largest average uplifts to acute providers – between 2-4% for the overwhelming majority of hospital trusts.

As most deficits currently sit with acute trusts, this supports the nationally-stated policy of prioritising financial recovery for the provider sector – a goal NHS Providers shares. However, prioritising acute funding means there is a significantly lower rate of tariff growth for the community, ambulance and mental health

sectors – between 0-1.5%. Although local pricing has a bigger impact in these sectors than the national tariff, local budgets are finite. The likely impact therefore will be that commissioners will have to trade off between planning for realistic increases in acute emergency demand and the requirement to expand and enhance mental health and community care. There is a risk that in order to appropriately resource the former, the latter will be delayed until later in the five year funding settlement period, which runs against the stated aims of the long term plan.

We would question why the uplift for independent providers is higher than for any category of NHS trust. The increase of between 4% and 7.2% for private providers, compared with range of 2% to 4% for acute trusts, is at odds with the stated goal of supporting acute sector recovery. It suggests that low-risk elective surgery, which makes up a higher proportion of independent providers' caseload, is being funded comparatively more generously than other forms of care.

Detailed feedback

Blended payments for emergency care

We remain concerned by the proposed changes to the payment system for emergency care, and are disappointed that the concerns we raised in the October engagement round have not been mitigated. We would therefore repeat the key points we raised earlier, which came from extensive engagement with provider trusts:

- Imposing a 20% marginal rate for any activity above planned levels loads the financial risk disproportionately onto the provider. Applying this punitive measure to acute trusts is not an appropriate response to a failure of the local system to forecast activity accurately, and to provide alternatives to hospital-based emergency care.
- The 20% rate does not take into account the high marginal costs of unplanned accident and emergency activity – for example the need to open extra beds or wards when demand exceeds what has been planned for. It also does not factor in the likely lost elective income as inpatient facilities are taken by emergency patients.
- The blended model only applies to the acute sector. It does not give all sectors, including primary, community, mental health and social care services, an equal stake in working jointly to reduce emergency activity.
- It is therefore hard to see how blended payments for acute providers for emergency care supports the wider policy goal of increasingly integrated local systems working with whole-population health budgets.
- The proposed approach leaves providers and commissioners with competing incentives. Commissioners have a clear incentive to forecast low activity growth as this will result in a lower contract value, while trusts will want a higher activity growth forecast to make it less likely the 20% marginal rate is imposed.
- Underpaying trusts for unplanned emergency activity recreates the negative impacts of MRET, which has rightly been abolished. It risks driving acute sector deficits in areas with high growth in emergency care in the same way that MRET did.

- Commissioners will find it difficult to produce a business case for any intervention to divert excess emergency activity if it is more expensive than funding conventional A&E activity at the 20% marginal rate.
- The failure to align incentives between providers and commissioners is likely to make contractual disputes more likely at the planning stage.
- The “break glass” measures similarly pit commissioner and provider interests against each other: where activity significantly exceeds plan, the provider will be motivated to renegotiate, while the commissioner will save money if it does not.
- The £10m eligibility threshold may be suitable for some providers. But for larger trusts that hold multiple contracts above the threshold, this mandated requirement will place a considerable burden on those negotiating contracts. Having several contracts subject to the blended system at once is also likely to make it harder to manage these contracts effectively in year. We ask NHS Improvement to consider alternatives for those larger providers that may be faced with negotiating multiple blended payments contracts.

Trusts are also concerned at the timescales for implementing such a significant change. The tariff documents have been published late in the planning cycle, giving local partners little time to understand their impact and agree a realistic contract.

We also note that two options for this payment system were put forward in the October engagement document. Although this is referenced in the statutory consultation, no explanation is given as to why one of these was picked over the other. Ideally there should be more transparency over these decisions.

Changes of this magnitude need careful planning and testing to ensure they have the intended effect, but this has not happened in this case. We are particularly concerned that the impact assessment published alongside the tariff assumed activity at 2016/17 levels, and that there was no deviation from plan. Such an outcome is highly unlikely, and therefore the true impact of these changes is not well understood.

We appreciate the intention that the details of blended payment contracts should be worked out via local negotiations. However there has been a general lack of clarity over how the model should be applied. We are aware, for example, of updates to the NHS standard contract which indicate commissioners and providers may be able to taper the variable thresholds above and below the agreed planned activity. However, no mention of this option is made in the statutory tariff consultation or the blended payments guidance, and so we are concerned some providers may not be aware such options exist during negotiations. Ideally, we would have liked to have seen much greater and extensive engagement with both the provider and commissioning sectors prior to the contracting round – both on the substance of the proposals and on their practical application. Before beginning to negotiate this new contract, providers should have been given detailed worked examples and testing of the model’s mechanics.

While we generally welcome the transfer of £1bn from the PSF to tariff, and specifically urgent and emergency care prices, we ask that consideration be given to those trusts unlikely to benefit from these changes, such as mental health, community, ambulance and specialist trusts. Ahead of next year’s national

tariff proposals, we ask for NHSI to evaluate the impact of the £1bn transfer and consult extensively with the entire provider sector ahead of further changes.

Blended payments for mental health

A blended payment system for mental health services appears to be a step in the right direction. We support the principle behind it, that it would add transparency by directly relating activity levels to payment, to better fund trusts for the work they do, and to support increased access to mental health services. We also hope it will provide an incentive for improving mental health coding and data.

However it will be important to recognise that setting a baseline for activity will be difficult, potentially time consuming and will likely require a significant resource commitment. Most providers and commissioners will be moving from block contracts, which do not contain the relevant detail needed to support the more nuanced blended contract.

We are concerned that the timescales for implementing these significant changes are too short. Furthermore, the proposals, which represent a major change to mental health contracts, were not outlined in the October tariff engagement and we therefore have concerns about whether there has been sufficient engagement on them over an appropriate time period.

Overall the blended payment system has the potential support the much-needed expansion and enhancement of mental health services. We are pleased that, unlike for emergency care, an arbitrary marginal rate has not been applied to the variable element. Provided accurate calculations can be made, providers should be paid according to their costs, meaning there would be no financial disincentive to expand access according to need. Where local agreement can be reached, the flexibility on which outcomes will be used will enable providers and commissioners to develop a shared set of priorities for their populations.

Outpatients

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 via changes to the national tariff rules is the best way to realise them.
Our concerns remain:

- Fixed costs associated with outpatient services – for example related to buildings or staff costs – cannot easily be cut even if the number of patients physically attending outpatient clinics reduces. The proposals would therefore introduce more cost pressures for the provider sector.
- Paying trusts less for face-to-face or consultant-led care creates a disincentive to use this model even when it is the most appropriate course of action. If patients need to see a consultant but do not, more follow up appointments will be likely in the long run.
- A non face-to-face appointment – for example via telephone or video link – will not necessarily use less consultant time than a traditional outpatient attendance. It will therefore be unlikely to cost trusts less.

- The proposal does not take into account the diversity of outpatient services: the potential for delivering high quality care remotely via video link will be greater in some specialisms than others. Likewise consultant-led care will be more necessary in some specialisms.
- Using staff other than consultants is only a viable option where those staff are available. For example, there may not be enough nurse consultants or consultant physiotherapists available to provide more outpatient appointments using a different workforce mix.

Centralised procurement

The proposal to fund Supply Chain Coordination Limited (SCCL) via a topslice of the tariff remains problematic and has the potential to undermine efficiency efforts in the provider sector.

We restate the arguments we and many others made in the initial engagement round:

- It is not the case that most procurement is currently done in an atomised way at trust level – much is already done collectively between providers on a regional basis.
- The assumption that the move from regional to national procurement will generate enough savings to cover the running costs of SCCL has not been tested.
- Funding SCCL via a topslice of the tariff loads all the financial risk associated with the new arrangements onto providers.

The decision to apply different topslices to acute, community, ambulance and mental health services, reflecting the fact that acute providers will use SCCL more than those in other sectors is, however, justified and welcome.

We maintain that the centralised service should be made available to trusts that are willing to fund it, and that SCCL's running costs should be funded via a mark-up on prices.

Maternity

As we set out during the October engagement that the introduction of non-mandatory prices for maternity is inconsistent with the well established approach to national tariff-setting, which encourages providers to focus on quality within a common financial envelope.

It is generally thought that this change will lead to increased administration costs and increases the risk of contractual disputes with commissioners which would take up considerable time and resource.

However, given the legislative restrictions in this area, we accept that it is unlikely an alternative arrangement can be drawn up ahead of the new financial year. We therefore ask NHSI to monitor the development of local maternity care contract negotiations closely, bearing in mind what the impact of these changes may have. Central bodies should also consult with the provider sector ahead of proposing any legislative changes to the government.