SCW

NHS
South, Central and West
Commissioning Support Unit

SCW'S RESPONSE TO THE 2019/20 PAYMENT REFORM PROPOSALS

SCW's multi-disciplinary teams are expert in assisting CCGs and other commissioning organisations contract for their strategic plans, secure health and care services that are focused on the local populations need, and secure continuously improving patient safety, quality and experience.

We recognise that the evolving NHS architecture is changing and our experience in supporting the standard NHS contract form as well as delivering new contracting approaches including Alliance Contracts, Aligned Incentive Contracts and Prime Provider Contracts', provides the insight we have used to inform our responses below.

We provide support to our clients through an objective, systematic approach, working within local systems to utilise regional clinical expertise, organisational subject matter experts and a degree of independence that can enable local system leaders to lead. With over 250 contract and financial experts there are always colleagues available to respond to even the most challenging of demands.

NHS Improvement and NHS England recently set out the main proposed changes to the payment system in 2019/20 and South, Central and West has facilitated responses to the proposals both directly and on behalf of customers. A summary of the main points to these responses is outlined below.

OVERVIEW

The survey accompanies the document 2019/20 payment reform proposals.

The document summarises some of the principal changes to the payment system NHS Improvement and NHS England are proposing to make for 2019/20.

INTRODUCTION

This document sets out the responses to the questions posed in the NHSI/E survey which was divided into a number of sections.

For clarity we outline the information outlined in each of the questions followed by SCW's response.

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DURATION OF THE TARIFF

We are proposing to set the next national tariff for one year only.

The vast majority of feedback we have received regarding the impact of the two-year tariff has been very positive. However, in setting the two-year tariff for 2017/19, we developed a method for assessing the appropriate length of the tariff.

Based on our criteria, we believe that the flexibility of a one-year tariff will be necessary to be able to respond effectively to developments taking place within the NHS, including the forthcoming release of the long-term plan for the NHS. Fixing a tariff for a longer period would limit our ability to make changes to support necessary strategic developments.

To what extent do you support this proposal?

- Strongly support
- **Tend to support** ✓
- Neither support or oppose
- Tend to oppose
- Strongly oppose
- Don't know

Do you have any comments on this proposal?

A one year tariff will provide the flexibility required for systems to:

- Explore, plan and transition to alternative payment and contractual mechanisms.
- Improve local costing systems and the required data flows required to support alternative payment mechanisms.
- The preference would be for a longer term tariff and the stability that this would provide, but we understand the need to retain flexibility to incorporate the long term plan.

BLENDED PAYMENT FOR EMERGENCY CARE

We propose introducing a 'blended' payment approach for emergency care.

This would comprise a fixed amount (linked to expected levels of activity) and a volume-related element that reflects actual levels of activity.

The payment model would cover A&E attendances, non-elective admissions (excluding maternity and transfers) and, potentially, ambulatory emergency care. It would serve as the new 'default' reimbursement model, but would not stand in the way of local systems continuing to move faster towards population-orientated payment models.

To what extent do you support a move to blended payment for emergency care?

- Strongly support
- **Tend to support** ✔
- Neither support or oppose
- Tend to oppose
- Strongly oppose
- Don't know

Please explain the reasons for your answer:

It would:

- Increase financial stability and reduce risk across the system.
- Protect fixed costs during a period of change, and therefore service continuity.
- Focus on the need for system wide growth reduction/alternative service delivery.
- Supports future development of alternative payment mechanisms.

What do you feel would be the advantages and disadvantages of the options set out?

Option A

- Refer to points made in the design section below, applicable and required to support implementation of either option.
- Option A - 100% fixed, 20% of tariff for over/under performance.
- Main difference is the cash flow impact for provider and commissioner – this option provides 100% fixed element upfront (1/12).

Option B

- Refer to points made in the design section below, applicable and required to support implementation of either option.
- Option B - 80% fixed and semi fixed, 20% of tariff for all other units of activity.
- Cash flow impact - less upfront funding for provider 80% (1/12)
- Potentially an easier methodology to monitor and manage - simpler transaction calculation.

On balance, which of the two options do you prefer?

- Option A
- **Option B** ✓

To what extent do you agree that the blended payment approach should…

	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know
Include a 'break glass' threshold		✓				
Have a threshold below which the blended model wouldn't apply				✓		
Have a 'collar' around the planned activity level where the variable rate would not apply				✓		
Cover ambulatory emergency care		✓				
Exclude specialised commissioning		✓				

Are there any other design elements you think will be important?

- For both options defined business rules will be required in relation to:
    - The agreement of baselines – in particular the potential inclusion of current MRET and readmission adjustments as indicated on the webinar
    - Cost neutrality process for commissioners and providers in relation to MRET & readmissions
    - Existing and planned commitments/schemes that impact the baseline on a recurrent and 2non-recurrent basis
    - 'Break Glass Rule' – tolerance rates need to be defined
    - BPTs and application under this payment mechanism.
- Consideration of levels of acuity included in the baseline and how any future changes could impact in year.
- Monitoring of readmissions from a quality perspective – we need to define how this will be undertaken.
- Introducing a de minimis threshold potentially adds to the complexity from a monitoring, payment and reconciliation point of view. If a de minimis threshold is introduced systems will need to understand the potential financial impact in terms of the achievement of 'cost neutrality'.
- De minimis threshold – confirmation required regarding whether this would be a guideline or mandated.
- Evidence base for fixed / variable rates – not necessarily the same for all providers.
- Cash flow implications.

How do you think providers and commissioners could best be supported to agree a planned level of activity?

For example, this could be nationally set assumptions, a national default or using three-year average growth

- Clear guidance, detailing the methodology, with nationally set assumptions to remove ambiguity and protracted contract negotiations.
- Generally opposed to a nationally set default baseline due to the need to reflect local agreements.
- Parameters of the 'Break Glass' clause.

Are there any barriers that you think might make implementing a blended payment approach difficult?

- Agreeing the baseline – incorporating the cost neutral aspect.
- Timelines – publication of the national planning guidance, ability to model the implications and agree contracts within the timeframe.
- Fixed/variable rates applied at a national average level v provider specific.

Do you have any other comments on this proposal?

- Ideally include Ambulatory Emergency Care (AEC) but the complexities need to be modelled and understood in a short timescale.
- AEC - A potentially contentious issue whether included or excluded from the blended payment approach, the tariff structure has not been adequately updated to reflect this pathway, in many circumstances this has resulted in short stay admission charges for a significant level of activity that previously would have attracted A&E prices. Key issue is data collection – development of a new POD is required to support coding and monitoring.
- 'Cost' will be based on HRG prices v open book cost approach – it might be helpful if there is any option to pursue this as an alternative.
- If providers and commissioners pursue an 'open-book accounting' approach, they would potentially be able to produce a more accurate fixed/variable split.

OUTPATIENT ATTENDANCES

We are proposing to create non-mandatory prices for non-face-to-face follow-ups for specialties with national prices.

We would also create non-mandatory prices for non-consultant-led first and follow-up attendances.

To what extent do you support this proposal?

- **Strongly support** ✓
- Tend to support
- Neither support or oppose
- Tend to oppose
- Strongly oppose
- Don't know

Do you have any other comments on this proposal?

- This will enable benchmarking and inform negotiation of local prices.
- Non-face-to-face will potentially release capacity that can be used to reduce RTT waits. However impact on cost is dependent on innovative methods of delivering non-face-to-face and whether capacity can be reduced without impacting RTT.
- Non-mandatory-non-consultant-led prices – support, but in practice the majority of clinics are defined as consultant led, therefore strongly support longer term plan for single tariff regardless of delivery method or healthcare professional, as this should drive increased efficiencies, innovation, and better patient experience.
- Agree with proposal to adjust the 'front loading' for services that require regular on-going follow up appointments.

MARKET FORCES FACTOR

We propose updating the method used for calculating the MFF and the data it is based on.

The proposed key changes are:

- Using travel to work areas (TTWAs) (rather than PCT area) for the non-medical and dental staff index
- Including business rates
- An effective reduction in the weight of the land index from an improvement in how the components are combined into a single MFF value
- Using the latest available data to calculate the MFF index.

See Market force factor review and update for more details of the proposed changes. There is also a more detailed survey available to collect feedback on the MFF proposals

To what extent do you support this proposal?

- Strongly support
- **Tend to support** ✓
- Neither support or oppose
- Tend to oppose
- Strongly oppose
- Don't know

Do you have any other comments on this proposal?

- Support the need to update the methodology and underlying data, this should occur each year going forward and on a consistent basis.
- Net national change will feed into tariff prices but difficult to establish the overall impact on systems without modelling all components, including the impact on CCG allocations.
- The potential for this to destabilise providers at a local level is a concern. The net impact for local providers cannot be modelled until all factors are published.
- Support the 4 year transition period which should help to mitigate any significant shift for providers.

CENTRALISED PROCUREMENT (SCCL)

NHS Supply Chain is being reorganised and managed by a new organisation, Supply Chain Coordination Limited (SCCL).

SCCL aims to increase NHS purchasing power and give providers access to lower procurement prices.
SCCL estimates that its overheads will be around £250m in 2019/20. We are asking for feedback on potential approaches to funding these overhead costs.

Currently, NHS Supply Chain is funded through a mark-up on the prices it offers. The Department of Health and Social Care intends that SCCL will receive central funding from the NHS England budget to pay for its overheads. This would reduce the cost to NHS providers of procuring supplies from SCCL.

If we were to recover SCCL's overhead costs through lowering the tariff, we could reflect this by reducing the overall tariff uplift factor, lowering national prices. The estimated overhead costs of SCCL are around 0.35% of the total amount covered by the National Tariff Payment System.

If we were not to do this, NHS England would not be able to provide central funding and SCCL would need to recover its overhead costs through increased mark-ups on product prices.

Tariff cost uplift factor: **Mark-up on SCCL product prices** ✓

Please explain the reason for your answer:

- The benefits of changing the method for funding the overheads from mark up on prices to adjusting the tariff are debatable, the obvious benefits are:
    - Guaranteed overhead recovery received upfront.
    - Application of a relatively straightforward adjustment to tariff uplift to fund the overheads.
    - All parties would have an incentive to be part of and to support the national scheme.
    - A mark-up on price could lead to over/under recovery of overheads.

However:

- No incentive for SCCL to reduce overheads if fully funded up front.
- Impact on providers if adjusted via tariff – potential double impact for providers given assumed level of efficiency already reflected in tariff, and if prices are not efficient provider will bear the risk.
- Reducing tariff uplift across all prices will potentially distort HRG prices and will not reflect resource usage.
- Need to consider potential impact on a Trust that may not use particular products.
- Mark-up will allow price comparison over time and between providers.

Do you have any other comments on this proposal?

- Potentially explore application of a risk/reward basis for funding the overheads, dependent on level of savings achieved by SCCL.
- Transparent reporting of the financial impact of SCCL.

MATERNITY

We are making all maternity prices non-mandatory to address the issue that the maternity pathway payment includes some public health services, known as Section 7A public health services.

These services fall outside the scope of national prices in the national tariff. We are also proposing some other changes to the pathway (see questions below).

Making all maternity prices non-mandatory

To what extent do you support the move to non-mandatory prices?

- Strongly support
- **Tend to support** ✔
- Neither support or oppose
- Tend to oppose
- Strongly oppose
- Don't know

Do you have any other comments on this proposal?

- Non-mandatory shift is not ideal, however we understand the need to address the section 7a public health services.
- Agree with the 'strongly advised to use' statement, otherwise this could become another area for local agreement and lengthy negotiation.

Specialist fetal medicine

We propose to remove specialist fetal medicine from the scope of national prices. NHS England would directly reimburse designated providers, operating a networked hub-and-spoke approach, for the care provided.

To what extent do you support this proposal?

- **Strongly support** ✔
- Tend to support
- Neither support or oppose
- Tend to oppose
- Strongly oppose
- Don't know

Do you have any other comments on this proposal?

- Support rationale however the methodology for allocation adjustments would need to be defined.
- Data availability and accuracy required to adjust baselines will need to be considered.

Delivery payment levels

We are considering moving from two payment levels to a six- or 36-level payment approach. The 36-level payment approach would mean providers are reimbursed on the basis of each of the 36 birth HRGs; the six-level approach groups the HRGs together, reflecting clinical complexity.

To what extent do you support the proposal to introduce more granular payment levels?

- **Strongly support** ✓
- Tend to support
- Neither support or oppose
- Tend to oppose
- Strongly oppose
- Don't know

If a more granular approach was introduced, would you prefer six or 36 levels?

6 levels	36 levels
✗	✓

To what extent do you agree that the potential negative impact on providers offering home births should be mitigated?

- Strongly agree
- **Tend to agree** ✓
- Neither agree nor disagree
- Tend to disagree
- Strongly disagree
- Don't know

Do you have any comments on the proposal to move to more granular payment levels?

- We support that cost should more accurately reflect the casemix.

Abnormally invasive placenta (AIP)

We propose removing abnormally invasive placenta from the scope of national prices. Care would be delivered from a number of specialist centres and be directly reimbursed by NHS England Specialised Commissioning.

To what extent do you support this proposal?

- **Strongly support** ✓
- Tend to support
- Neither support or oppose
- Tend to oppose
- Strongly oppose
- Don't know

Do you have any comments on this proposal?

- The methodology for allocation adjustments need to be defined.
- The data availability and accuracy required to adjust baselines will need to be considered.

Postnatal complexities

We propose to update the complexity factors for the postnatal phase and change the casemix assumptions used to calculate postnatal phase prices.

To what extent do you support this proposal?

- **Strongly support** ✓
- Tend to support
- Neither support or oppose
- Tend to oppose
- Strongly oppose
- Don't know

Do you have any comments on this proposal?

- We support that cost should more accurately reflect the casemix.

MENTAL HEALTH

In the 2017/19 NTPS we introduced local pricing rule 7.

We propose changing the rule to mandate a blended payment approach for mental health services for working-age adults and older people. This would consist of a fixed element based on forecast activity, a variable element and an element linked to locally agreed quality and outcomes measures. There would also be an optional risk share to promote collective management of financial risk.

We also propose publishing non-mandatory guide prices for improving access to psychological therapies (IAPT) assessment and treatment.

To what extent do you support this proposal?

- Strongly support
- **Tend to support** ✔
- Neither support or oppose
- Tend to oppose
- Strongly oppose
- Don't know

Do you have any other comments on this proposal?

- All elements are dependent on the quality of local data to:
  - Provide an informed view regarding the complexity of the casemix.
  - Establish an accurate forecast and to be assured when considering the variable element once delivered.
- The inclusion of a financial risk share will potentially mitigate.
- IAPT - support a benchmark non-mandatory price.

OTHER AREAS OF WORK

This section contains questions on:

- Currency design and specification
- Evidence-based interventions
- Best practice tariffs
- High cost drugs and devices
- Price and revenue volatility adjustments
- Specialist top-ups
- Non-mandatory prices.

You do not have to answer all questions and please scroll down to find the areas that you are interested in.

Currency design and specification

We propose to continue using the HRG4+ currency design to set national prices, moving to the version used for 2016/17 reference costs. We would also create national, rather than non-mandatory currencies for both wheelchair and spinal cord injury services from 2019/20.

To what extent do you support this proposal?

- **Strongly support** ✓
- Tend to support
- Neither support or oppose
- Tend to oppose
- Strongly oppose
- Don't know

Do you have any other comments on this proposal?

- Using the most up to date version strongly supported.
- Tend to support national currencies for wheelchair and spinal injury services.

Evidence-based interventions

The recent consultation on evidence-based interventions included the following proposal:

Introduce zero payment for Category 1 interventions without IFRs [individual funding requests]

For the four Category 1 interventions we propose to no longer routinely commission, we will consider how the National Tariff and the NHS Standard Contract could be changed to support this clinically led change. For the Tariff, we will consider removing Category 1 from the scope of the National Tariff price or establishing a national variation, so that providers are not paid for activity unless in exceptional circumstances, where prior approval of an IFR has been given by the commissioner. We want to implement this change as quickly as possible, and are proposing it applies from April 2019. We would welcome views on this. If an IFR is made, providers would be paid under the existing tariff.

To what extent do you support the implementation of this proposal in the national tariff payment system from April 2019?

- Strongly support
- **Tend to support** ✓
- Neither support or oppose
- Tend to oppose
- Strongly oppose
- Don't know

Do you have any other comments on this proposal?

- Identification of this activity - assume the grouper will flag.

Best practice tariffs

We propose to introduce two new BPTs:

- One for emergency laparotomy to increase the proportion of patients whose surgery is directly supervised by both a consultant surgeon and a consultant anaesthetist, and who are transferred directly to a critical care unit from theatre.
- One for spinal surgery to cover all admissions for HRGs HC50-64. Payment of the BPT would depend on submission of data to the British Spinal Registry (BSR). We are considering setting the organisation-level attainment rate at 80% and having a 10% differential between the BPT price and the standard price.

We are also considering updates to existing BPTs, following feedback from users or as a result of new data becoming available, to ensure the BPTs are able to achieve their intended purpose.

To what extent do you support these proposals?

- Strongly support
- **Tend to support** ✓
- Neither support or oppose
- Tend to oppose
- Strongly oppose
- Don't know

Do you have any other comments on this proposal?

- We support the principle of BPTs, coding that has been clinically led requires implementation to ensure BPT can be utilised across healthcare delivery to effect outcome improvement and reduce unwarranted variation.
- However this needs to be balanced against the administrative burden of data capture and validation, especially where there is no central collection.
- Impact on use of BPTs with regard to the blended payment approach needs to be considered.
- Preference would be to address 'best practice' via NICE guidance and mandating through a quality route as opposed to using tariff.

High cost drugs, devices and listed procedures

There are 406 drugs on the high cost list published as part of the 2017/19 NTPS. For 2019/20, we propose to remove 47 drugs; add 109 drugs and amend one drug on the list.

We propose to add three devices to the high cost devices list and clarify that three devices nominated for inclusion on the list are covered by existing categories. We would also expand the guiding principles used to determine the high cost list to support procurement arrangements introduced by NHS England Specialised Commissioning.

We also propose to make changes for molecular diagnostic tests, so that: five of the current six tests are removed from the list of excluded procedures; Oncotype DX and PD-L1 are retained on the list; EndoPredict and Prosigna are added to the list.

For details of all proposed changes to the drugs and devices list, see the Draft price relativities workbook.

To what extent do you support these proposals?

- Strongly support
- **Tend to support** ✔
- Neither support or oppose
- Tend to oppose
- Strongly oppose
- Don't know

Do you have any other comments on this proposal?

- Support needs to be based on the application of Nice /clinical evidence.

Price and revenue volatility adjustments

We propose to continue adjusting prices to mitigate the impact of the move to HRG4, so that affected services are reimbursed 50% of the loss, rather than the 75% in the 2017/19 NTPS. We are also proposing to introduce any changes in MFF values over a number of years.

To what extent do you support these proposals?

- Strongly support
- **Tend to support** ✓
- Neither support or oppose
- Tend to oppose
- Strongly oppose
- Don't know

Do you have any other comments on this proposal?

- A method to reduce risk was introduced previously and is expected.

Specialist top-ups

We propose working with NHS England Specialised Commissioning to update the Prescribed Specialised Services (PSS) Identification Rule (IR) and Provider Eligibility Lists (PELs). We would implement the second 25% step in the four-stage transition for orthopaedics, paediatrics and spinal cord injury services, who lost funding after PSS began to be used for specialist top-ups.

Draft specialist top-up flags and rates are available in the Draft price relativities workbook.

To what extent do you support these proposals?

- Strongly support
- **Tend to support** ✓
- Neither support or oppose
- Tend to oppose
- Strongly oppose
- Don't know

Do you have any other comments on this proposal?

- A method to reduce risk was introduced previously and is expected.

Non-mandatory prices

We propose to clarify the intention behind new non-mandatory prices and whether they are intended as testing prices or benchmark prices. Testing prices are based on reference cost data and calculated using the same method as national prices. Benchmarks prices are intended as a guide to aid local price-setting.

We propose to introduce testing prices for wheelchair services and renal transplantation. We propose to introduce benchmark prices for services including advice and guidance, IAPT and specialist rehabilitation.

For more details, see the Draft price relativities workbook.

To what extent do you support these proposals?

- Strongly support
- **Tend to support** ✓
- Neither support or oppose
- Tend to oppose
- Strongly oppose
- Don't know

Do you have any other comments on this proposal?

- We tend to support subject to accuracy of underlying cost data.

SCW

Our hummingbird was chosen for more than its aesthetic appeal.

It represents determination, endurance, flexibility, adaptability, resilience and great courage. The very characteristics we will demonstrate in our work with our customers.

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