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Dear Bob,

National Tariff 2017/18 and 2018/19

Who we are

The Healthcare Financial Management Association (HFMA) is the representative body for finance staff in healthcare. For the past 60 years, it has provided independent and objective advice to its members and the wider healthcare community. We are a charitable organisation that promotes best practice and innovation in financial management and governance across the UK health economy through our local and national networks. We also analyse and respond to national policy and aim to exert influence in shaping the wider healthcare agenda. We have a particular interest in promoting the highest professional standards in financial management and governance and are keen to work with other organisations to promote approaches that really are 'fit for purpose' and effective.

Our comments

The tariff engagement document has been considered by members of our National Payment System Special Interest Group, Prescribed Specialised Services Commissioning Special Interest Group and Mental Health Finance Faculty Steering Group. All draw their membership from across a wide range of organisations working in the NHS.

We welcome the move to release information relating to the coming year's National Tariff at the earliest opportunity. However, it is our understanding that the updated identification rules will not be available until October and our members have noted the additional difficulty that this presents when forming a response.

Whilst we welcome the regular presence of colleagues from both NHS Improvement and NHS England at our meetings, we would like to take this opportunity to comment on the following issues.

Multi-year tariff

We have broadly supported the principle of a multi-year tariff for a number of years and recognise its role given the current need for greater stability to facilitate longer term planning and a return to financial balance.

While we recognise a number of benefits of introducing a multi-year tariff, in our view the assumptions used around cost inflation, CNST and efficiency must be very clear, transparent and evidence-based. We also recognise that some annual price changes reflect the costs associated with developments in medical practice and technology and quality measures. Simply applying an uplift across all tariff prices may create additional pockets of financial pressure for providers.

If the tariff is fixed for two years, this must mean that it is indeed fixed for the predetermined period. Any additional changes in policy cannot then be introduced without presenting additional pressures to an already overstretched provider sector. However, it is also important to recognise circumstances where the in-built assumptions of a multi-year tariff are materially breached and require revisiting prior to the next tariff review.

In our view, multi-year tariffs cannot be introduced in isolation and in the absence of wider changes to the financial arrangements already in place across the NHS. We would therefore welcome the moving of other elements of the system to a longer time frame - for example, a two year pay settlement and contracting period.

Currency

As we are sure you will recall, our members broadly support the move to HRG4+ phase 3 on the basis that:

- A period of stability will follow its introduction
- The reference cost information used to calculate prices will be brought more up to date (2014/15)
- Separate work will continue to understand and correct orthopaedic prices (in our view, the issues surrounding orthopaedics are significant: unstable prices; the move to HRG4+; transitional support if top-ups are removed and changes to best practice tariffs). It would be helpful to understand why this situation has arisen
- Separate work will also continue in relation to existing specialist top-ups to understand the extent of any further adjustments that might be appropriate for specialist providers.

However, we are concerned that as this is a fundamental change and alongside the other changes proposed, it will be difficult to ascertain the impact of its introduction.

Smoothing

The combined effect of the changes on providers of prescribed specialised services is of particular concern. The National Payment Systems Special Interest Group has previously considered the complex issue of smoothing and concluded that it may be most appropriate at individual provider level. From a commissioner's point of view, the amount and impact of any transitional funding is best shared with the host clinical commissioning group in order to inform and plan for transformative change. In our view, any smoothing or transitional support must insulate providers and commissioners against an undeliverable pace of change.

Top-ups

In our view, it is still vital to be able to identify and understand whether the change in currency either a) negates the need for specialist top-ups or b) means that there is a continued need for top-ups at the existing or different rates. In our view, it is important that

the full picture, including any changes to existing top-up arrangements is properly assessed and considered before being locked into a multi-year tariff.

We have continued concerns about the aggregated data used by the University of York in relation to top-up rates and that existing matters relating to top-up payments and the funding of complex care have still to be resolved.

High cost drugs and devices

Providers of prescribed specialised services are also impacted by changes to the tariff exclusions list (drugs and devices). If the multi-year tariff is introduced, this requires a sensible and flexible approach, particularly by NHS England should new National Institute for Health and Care Excellence (NICE) approvals or recommendations take place before the tariff is due to be revised.

Conversely, where the cost of devices has been incorporated back into national prices, providers need to fully understand the value that has been included by healthcare resource group, particularly where NHS England procures a device nationally on behalf of all NHS providers. Individual NHS organisations need to know what to stop charging for separately and when the national arrangements have been put into place. Our members have also expressed concerns regarding the averages being used and the range of costs to which those averages have been applied.

Outpatient follow-ups

We were surprised to see the proposals relating to the payment of outpatient follow-up appointments (a block payment) and at a time of endeavouring to move away from unaccountable block contracts in mental health services, their reintroduction elsewhere. We would like to better understand what the proposed changes to outpatient prices are specifically designed to achieve. Whilst we understand the need to ensure that all clinical visits add value, we are not clear how a crude change in the currency - in the move to a block, may achieve this. For example, an improved respiratory pathway with improved access to an ambulatory care follow up setting may be negated by such a move. More follow up outpatient visits, may be optimal in this case.

Payment for outpatient follow-up appointments is a significant part of a trust's income and it is our view that the measures as they currently stand may incentivise providers to stop providing outpatients earlier whether or not this is clinically suitable. There is a lack of evidence and clinical rationale to support the proposals and it is our view that the objectives could be better achieved via the use and application of benchmarking data. For example, each NHS healthcare provider should regularly be reviewing new to follow-up ratios against nationally available data and making operational decisions on that basis.

In addition, the introduction of block payments could stop the search for and implementation of innovative solutions to move care out of a hospital setting. Where this has already been achieved and outpatient services have been reconfigured to reduce face to face appointments, any money released will already have been diverted elsewhere and as such there is no opportunity for a gain share arrangement to facilitate the introduction of new payment arrangements.

Given that commissioners and providers can currently spend a good deal of time debating appropriate new to follow up outpatient ratios, we are not sure more local latitude on

approaches to outpatient reimbursement will necessarily deliver improved pathways. We also believe it would be difficult to determine an appropriate contract value as well as undermining the ability to flex reimbursement in line with activity levels and support the critical policy of patient choice. In our view, and in the context of finalising plans and contracts by the end of the calendar year, the need to reach agreement on payment will lead to a raft of extra discussions and potential disagreements locally, and take up a lot of unnecessary time and effort that could be better used elsewhere.

Metrics engine and quantum

We welcome the introduction of the metrics engine. Our members have repeatedly asked for increased transparency with regard to the price setting process and we see the metrics engine as a positive step in this direction. It does however make apparent the impact of converting to spells using hospital episode statistics.

Activity quantum

Hospital episode statistics include all patient activity not just that appropriate for billing and pricing purposes notably private patient activity, 'year of care' activity and any highly specialised activity subject to a local agreement - for example, transplant, long term ventilation, primary ciliary dyskinesia. Consequently, too much activity is included requiring subsequent deflation to the reference cost finished consultant episode (FCE) quantum. We have continued concerns that the impact of this is still not fully understood. In our view, it would be more appropriate to use the reference cost spell activity (and quantum) that matches the FCE submission (and quantum).

Financial quantum

The metrics engine also highlights the scaling of any unachieved efficiency requirement. The model shares any under performance against efficiency targets across all providers (whether or not they are achieving their own efficiency target). In our view, a two year tariff means that it will be necessary to estimate the associated level of leakage for the second year (based on reference costs for 2015/16). As a result, there is an inherent and additional efficiency requirement incorporated into the tariff - particularly for the providers who do achieve their efficiency requirements in year one.

The financial quantum is affected by the provider sector overspend in 2015/16. In 2016/17 the sustainability and transformation fund is being used to balance this issue. It is vital to understand whether or not the sustainability and transformation fund will sit inside or outside of the tariff setting process for 2017/18 and 2018/19. In our view, either the amount of the deficit and the fund are excluded; or the deficit and fund are both included. Whichever approach is adopted, it must be transparent and clearly understood.

Mental health payment approaches

In our view, progress must be made in relation to currencies and payment models in mental health; however, we are concerned that a number of local health economies are some way from implementing new and/ or different arrangements. In our view key challenges remain:

- Commissioner reluctance and/ or lack of engagement
- The continued use of block contracts irrespective of national guidance

- The lack of widespread use of risk sharing agreements between commissioners and providers across all elements of the contract
- The level of current data quality for the whole patient pathway and the absence of mandatory format requirements
- Readiness for appropriate data collection to inform any new arrangements
- The wider financial agenda.

We are also concerned that the proposals allow for the continued use of 'alternative arrangements' – whilst providing a degree of flexibility for local providers and commissioners, it is unclear what such suitable alternatives may be.

Sustainability and transformation plans

We are also concerned about the role of a National Tariff in the wider context of sustainability and transformation planning. Organisational control totals are at risk of being undermined by the introduction of significant changes to the National Tariff. In our view, the overriding objective is to implement an affordable, clinically and financially sustainable system wide response to the physical and mental health needs of local populations articulated through the sustainability and transformation plans.

We hope that you find these comments made on behalf of our members useful. Please feel free to contact Sarah Bence (sarah.bence@hfma.org.uk) if you need clarification on any of the points made above.

Yours sincerely

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Chair, HFMA National Payment Systems Special Interest Group

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