NHS Clinical Commissioners response: 2016-17 National Tariff proposals

21st September 2015

I. NHS Clinical Commissioners

NHS Clinical Commissioners (NHSCC) is the membership body of Clinical Commissioning Groups (CCGs) established in 2012 and representing 86 per cent of CCGs in the NHS. We offer a strong national voice for our members on a number of policy issues and support them to be the best they can in order to commission effectively for their local populations.

We welcome the opportunity to provide the CCG perspective on the proposals for the 2016-17 National Tariff and our response will align with direct responses from CCGs, which we have encouraged. To develop this response we have engaged our members via our finance forum and held a national member webinar with colleagues from NHS England and Monitor participating. Feedback was also received from members of the NHS Commissioning Assembly Finance Working Group (CAFWG).

II. Main messages

The *Five year forward view* (5YFV) sets out the vision for what we want to deliver in this parliament.¹ CCGs are determined to make this vision a reality and need support from national bodies to ensure the right environment for them to do so. This includes using enablers to transform care to meet the needs of people today. The key messages of our submission therefore are requests for increased clarity, transparency, and certainty in the funding mechanisms which will allow this to occur.

CCGs want to change how care is delivered and this vision rests on a community-based model with greater investment in out-of-hospital services. Their scope to do this is hampered by resources available locally, in particular the large amount of spending on acute providers. There is better value in expanding access to care closer to home, which in many cases represents the right care in the right place. The role of the payment system is important in this context because it currently drives activity into hospitals, rather than the reverse. This behaviour was acknowledged by Monitor and NHS England when it took control of the NHS payment system.²

*Pace of reform*

Monitor and NHS England have set out how the 5YFV will be supported by reform to the NHS payment system.³ We’re pleased to see a continued focus on integrating care with the suggested move towards services paid on a capitated basis and an emphasis on the outcomes delivered. This will have a big impact on how CCGs approach commissioning in their local areas.

It’s clear though that the pace of reform is an urgent issue to be addressed. Changes to the payment system have been slow and while the focus has been on improving the building blocks, this seems to be at the expense of bolder changes. The 2016-17 National Tariff proposals are a demonstration of this incremental

1 NHS England – *Five year forward view*, October 2014
2 Monitor and NHS England - *How can the NHS payment system do more for patients?*, May 2013
3 Monitor and NHS England - *Reforming the payment system for NHS services*, December 2014
approach and it makes small amendments, which further prolong the delay in implementing bold reform on tariff.

One bold reform this pushes further into the future is the move to a multi-year tariff cycle. Having greater certainty on prices and efficiency over a longer period than one year would be a catalyst for strategic planning in the NHS and support local systems to discuss how to meet the challenges they face. CCGs are keen to focus on how they can change care within the next five years and to do so they need a perspective that goes beyond a single financial year. They will need the resources in the next few years to invest in primary, mental health and community services to allow benefits to be realised in the last few years of the parliament. Multi-year prices could help to support these plans, while offering providers a practical guide to the expected change in prices.

2016-17 tariff engagement

We think some of the suggested changes in the 2016-17 National Tariff will improve the basis on which prices are set and are concerned about the impact other proposals might have on CCGs. This is outlined in the specific comments below, although more broadly we are uneasy about decisions that will come later in this process and will have the biggest impact on our members. This includes the setting of the efficiency factor, which will establish how far prices across-the-board will be reduced to prompt providers to reduce their costs each year.

The process for setting national prices is more transparent than before. CCGs have had a strong presence at Monitor and NHS England workshops both before the summer, as proposals were being developed, and in the last few months to feedback on the suggested reforms. An enhanced impact assessment would seem to be an improvement to the process as well, although we are keen to ensure CCGs are better engaged and involved in the modelling that takes place.

Nonetheless, recent improvements in engagement highlight areas where there is still work to be done, in particular in the later stages of the process, which the 2016-17 proposals are yet to go through. Overall, we would like to see a recognition from the national bodies of the need to improve engagement with the NHS as it develops tariff proposals. The last few years have seen tensions in the final prices agreed and while this reflects the tough financial environment, we’d be keen for a stronger attempt at whole systems solutions from the start. This would be more constructive and, more importantly, would help build agreement on final prices, which would enable commissioners and providers to discuss how best to manage risk locally and alignment to existing local initiatives. It would be beneficial to strengthen risk sharing through the tariff when changes are implemented and assess the impact of the proposals in light of other incentive schemes, for example CQUIN and future coding, since this can create unplanned pressures on the cost of emergency admissions.

Limits of the tariff

The efficiency factor has been an important feature in the last five years and it has helped to reduce costs, supporting CCGs to manage the fact that funding is lagging behind demand. Nonetheless, it’s clear this approach is having an impact on provider finances with the sustainability of some services being questioned. To deliver the 5YFV and establish greater sustainability in the NHS, it is clear that simply reducing prices will not be enough to make savings and there needs to be a more holistic approach that moves from the technical to the allocative.

This will shift the focus to local commissioning, which is best placed to ensure a more equitable distribution of resources based on needs and improving outcomes. This approach will be harder to achieve if CCGs are having to prop up the finances of providers and the payment system needs to be set up to reward where local systems are looking to do this.

More broadly though, shifting the focus would recognise the limits from driving behaviour, in this instance on savings, through the national tariff. No matter how far we improve mechanisms the prices set are always likely to be crude, in terms of understanding the challenges faced in different local systems. This reinforces the need to allow local discussions to set prices and to move to an approach that puts CCGs in a better position to facilitate change.
III. Specific comments

The proposals in the tariff document are generally sensible and we agree with a lot in principle from what is suggested. Nonetheless, we have specific comments below that identify CCG views on the proposals put forward.

Relative prices

Our comments are focused mostly on national variations and locally determined prices, which this response is responding to. In terms of the currency design and relative prices, we support the move towards more sophisticated currencies, such as HRG4+, and the expanding of best practice tariffs to ensure more prices reflect an efficient approach to delivering services. We do offer a word of caution to national bodies about the proposals to set national prices in neurology and renal dialysis, as these will be soon moving to within the scope of CCGs. As such, it is important to manage the transition of the commissioning function for these services to ensure it is as smooth as possible, rather than setting CCGs a tough challenge from the start.

Overall, the impact of the prices on CCGs is shown to be disparate, which reinforces the importance of national bodies being responsive to these changes. The impact assessment suggests CCG spending would drop by 0.15 per cent on average, before accounting for variations, yet some CCGs are suggested at seeing a drop of around 1.3 per cent and others an increase of more than 1 per cent. This is in the context of a small CCG surplus, of 0.3 per cent, and increasing signs of strains on the commissioning side.

Significantly, the local impact statements are not reflective of the national work undertaken on HRG4+ impact across commissioners. We are therefore concerned that this would increase pressure on CCG commissioned services at a time when the CCG sector is already working to capacity and may lead to downstream objections to the tariff which would not be in the best interests of patients.

Marginal rate for emergency admissions

The proposals on the marginal rate for emergency admissions are the same as are in place for the enhanced tariff options, which the majority of providers chose earlier this year. Nonetheless, we will re-emphasise the points we made in our previous response to these proposals.

We understand the need to maintain the marginal rate for emergency admissions, in order to address the serious pressure that rising admissions pose to the whole system. We recommend that our members continue to use the marginal rate as a mechanism for investing in alternatives to acute care that aim to reduce hospitalisation and better manage the needs of high-risk patients with long term conditions. Nonetheless, we are keen for greater pace in the move to a new urgent and emergency care payment system, so as to have a greater emphasis on quality and outcomes. There was concern expressed amongst our membership that there should be more flexibility around the base year, this would be dependent on whether changes have been made against the original threshold since 2008/09.

Previous planning & tariff guidance has suggested that the Marginal Rate Emergency Tariff (MRET) is non-recurrent each year and commissioners are required to show how money is used annually. In reality it may have been used to fund previous community-based alternatives to admissions that have not been identified. With an increase in MRET from 30% to 70% further pressure will be exerted on CCG finances as these costs would have to be recovered from other areas.

Local price modifications

The consultation also proposes a number of changes to the process for agreeing locally determined prices, including the dates at which CCGs will need to submit templates. We would like to see greater clarity from Monitor and NHS England on the application of local price modifications and how far they see these growing in the future. Certainly, if there were more examples of prices being increased to reflect pressures on providers, we would want to see greater clarity on the evidence on which these decisions are based. Some of our members have suggested it would be helpful to pursue lower local tariffs to reflect work required for a given procedure. We would also welcome the opportunity to agree lower price modifications if local circumstances warrant. Finally the new early cutoff date for local prices increases pressure on commissioners

NHS Clinical Commissioners – Mythbusting CCG finances, June 2015
to reach agreement with providers earlier, making it less likely that variations can be worked through under the new timescales.

**Excluded Drugs**

There is a need to ensure that the costs in the area of Excluded Drugs are managed by, and are the joint responsibility of, both providers and commissioners. This will ensure the best value and outcomes for patients.

**IV. Conclusions**

The 2015 Spending Review creates a challenge for setting prices this year because we will not know the exact funding envelope for health until November. Nonetheless, we mustn’t allow that to repeat mistakes in previous years where organisations have objected to the price-setting methodology.

This will increase the importance of even better engagement, which NHSCC is keen to facilitate further with national bodies to build the progress made already.

If you would like any further detail on our response please do not hesitate to contact our Head of Policy and Delivery, Julie Das-Thompson at j.das-thompson@nhsc.org.